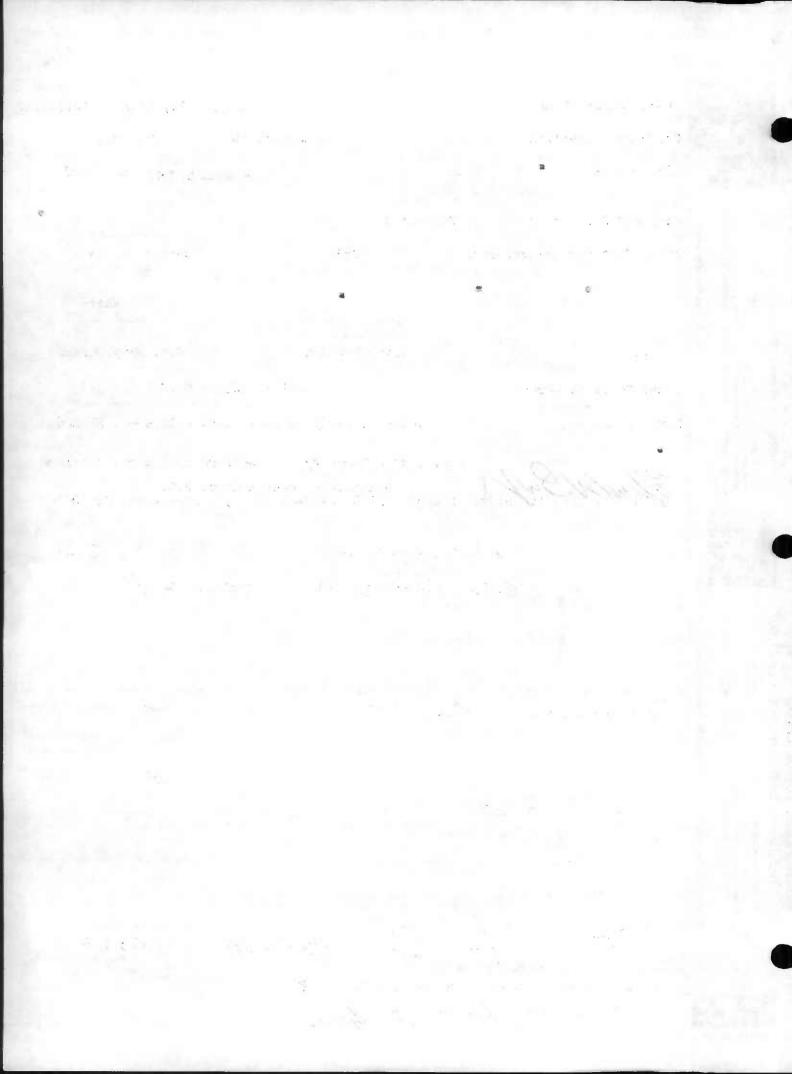
1. Decedent's Name (First, Middle, Las	()					2. Date of Dea	ith		3. Time of Death	
	•					Month	Day	Year Q.Q.	12:00p.m.	
				4	tb. City, Town, or Lo		-		12.00p.m.	
St. Mary's Hospit	al				Leonardt	own	St.	Mary	's	
	THE STEE				If Under 24 Hrs. Hours Min.			9. Birthpla Country Mary	ce (Stete or Foreign X) Land	
	10	c. Citv. Town or Le	ocation				•	100	d. Inside City Limits	
									1 ☐ Yes 2 ■ No	
	5	IIOII y WOO		Code			10g. Citizen of \	Whet Countr	y?	
26019 Sotterly He	ights Road		206	36			United	State	S	
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ■ No If Yes, Give Year or Dates:	in U,S. 13.				ecify Yes or No- Rican, etc.)		ck, White, et	c.	
15. Decedent's Ed	ucation de completed)	16a. Dece	dent's Usual	Occup	ation during most of work	ing	16b. Kind of B	usiness/Indu	stry	
Elementery/Secondery (0-12)	College (1-4or 5+)						II 0 N	10		
12 Father's Name (First Middle Lest)		61	VII Se	rva		/First Middle			erense	
								,6)		
		19b Maili	ing Address	(Street				Stete Zin C	Code)	
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						Date				
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21. Streeters Funeral Service Con	210	2	2. Name and	Addre	ss of Fecility			ou, m	alylanu	
CHMIN V	W							- MD	20650	
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resulting in death)	Due	to (or es a conse	quence of):)	1	13	A		
	b. Cere	lvova	sa	M	u /	4ccc	dent			
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resulting in death) Last	Due	to (or es a conse	quenca of):					1		
d.										
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						24a. Was	an aut <i>o</i> psy med?	avai	re autopsy findings flable prior to apletion of cause eath?	
						• []	(as 21)		Yes 2 No	
25. Wes case referred to medical					26. Place of Deat			,	139 ELI 140	
examiner?	Hospital:	2 ☐ ER/Outpatie	nt 3□ DΩ	A Oth				ner (Specify))	
27. Manner of Deeth	28a. Dete of Injury	28b. Time o								
2 Accident Investigation		an, injury	М							
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	286. Piece of injury	At home, farm, st pecify)	treet, factory	, offica		28f. Location (: City or Tox	Street end Numi vn, Stete)	ber or Rurel	Route Number,	
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29b. Signature and title of certifier	14	7	290	Licens	se number		29d. Date signe	d (Month, D	Dey, Yeer)	
) the	(1/2	mi)	4	352	30	8/	13/50	+	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)										
30. Name and address of person who completed cause of death (Item 23e) (Type, Print)										
	4a Facility Name (If not institution, give St. Mary's Hospit 5. Social Security Number 214-10-2009 11 5. Social Security Number 214-10-2009 11 10e. State 10b. County Maryland St. Mary 10e. Street and Number 26019 Sotterly He 11. Marital Status 1 Never Married Married 3 Widowed 4 Divorced 15. Decedent's Ed. (Specify only highest gree Elementery/Secondery (0-12) 12 17. Father's Name (First, Middle, Last) James Columbus Ch. 19a. Informent's Neme/Reletionship (7) Mary I. Chaney, 20a. Method of Disposition 1 Burial 2 Cremation 3 1 Denetion 5 Other (Specify 21) 12 17. Father's Neme/Reletionship (7) 19a. Informent's Neme/Reletionship (7) 19a. Informent's Neme/Reletionship (7) 19b. Informent's Neme/Reletionship	Usual Residence of Decedent 10e. State 10b. County Maryland St. Mary's 10e. Street and Number 26019 Sotterly Heights Road 11. Marital Status 1 Never Married 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) 12 17. Father's Name (First, Middle, Last) James Columbus Chaney 19a. Informent's Neme/Reletionship (Type, Print) Mary I. Chaney, Wife 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donetion 5 Other (Specify) 21. Furnament's Determined at the shock, or heart failure. List only one cause on each line. Immediate Ceuse (Final disease or conditions if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Part II. Other significant conditions contributing to death but not be determined 25. Wes case referred to medical examiner? 1 Yes 2 No 27. Manner of Deeth 1 No Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) 26. Due 27. Manner of Deeth 28. Dete of Injury, (Month, Dey Yes) 29. Accident 3 Suicide 4 Homicide 29. Cettleer of Could not be determined 29. Cettleer only one 20. Medical Examiner: On the basis of examinar marked and marrier stated	As Facility Name (If not institution, give street end number) St. Mary's Hospital S. Social Security Number 214-10-2009 1 Mary 7. Age (In yrs. lest birthdey) 1 Mary 10c. City, Town or Law 10c. City, Town or Law 10c. City, Town or Law 10c. State 10c. County 10c. City, Town or Law 10c. Street and Number 26019 Sotterly Heights Road 11. Marital Status 1 Never Married 1 Maried 1 Never Married 1 Never Mar	48 Facility Name (if not institution, give street end number) St. Mary's Hospital 5. Social Security Number 214-10-2009 11 M 2 F	48 Facility Name (if not institution, give street end number) St. Mary's Hospital 5. Social Security Number 214-10-2009 1	46. City, Town, or Let State Marry St. Marry	August As Facility Name (if not institution, plus sired and number) St. Mary's Hospital S. Social Security Number 2. Social S	James Gordon Chaney St. Mary's Hospital S. Social Security Number 214-10-2009 St. Mary's Hospital 10. Clay, Town or Location Hollywood 10. Steve Maryland St. Mary's Holy Heights Road 10. Clay, Town or Location Hollywood 10. Steve and Number 26019 Sotterly Heights Road 11. Marial Status 11. New Mariad 21 Mariad 12. Was Deposited Feer in U.S. 13. Was Decodent of Hispanic Origin? (Specify Year) 10. Steve Mariad 11. Marial Status 11. New Mariad 12. Was Deposited Feer in U.S. 13. Was Decodent of Hispanic Origin? (Specify Year or No-Water or Diales: 13. Was Decodent of Hispanic Origin? (Specify Year or No-Water or Diales: 14. Page 21 No. Specify 15. Second or Hispanic Origin? (Specify Year or No-Water or Diales: 15. Second or Hispanic Origin? (Specify Year or No-Water or Diales: 16. Decodent's Education 17. Year 21 No. Specify 18. Methor's Name (Frex. Middle, Last) James Columbus Chaney 16. Decodent's Education 16. Decodert's Usual Compation 17. Apa (Hispanic Origin?) 18. Methor's Name (Frex. Middle, Last) James Columbus Chaney 19. Malling Address (Steve and Number Chane) 20. Methor's Name (Frex. Middle, Last) 19. Malling Address (Steve and Number or Page 1) 19. Malling Address (Steve and Number or Page 1) 19. Malling Address (Steve and Number or Page 1) 19. Malling Address (Steve and Number or Page 1) 19. Malling Address (Steve and Number or Page 1) 19. Malling Address (Steve and Number or Page 1) 19. Malling Address (Steve and Number or Page 1) 19. Malling Address (Steve and Number or Page 1) 19. Malling Address (Steve and Number or Page 1) 19. Malling Address (Steve and Number or Page 1) 19. Malling Address (Steve and Number of Page 1) 20. Malling Address (Steve and Number of Page 1) 21. Very Clay or Page 1) 22. Numaria and Address or Page 1 23. Numaria and Address or Page 1 24. Clay or Page 1 24. Origin of Malling Address or Page 1 25. Numaria and Address or Page 1 26. Clay or Page 1 27. Numaria December of Page 1 28. Page 1 In Page 1 28. Numaria December or	August 14, 1998 August 14, 1998 St. Mary's Hospital Social Sourhy Number St. Mary's Hospital Social Sourhy Number St. Mary's Hospital To Republish St. Mary's Hospital St. Mary's	



State of Maryland / Department of Health and Mental Hygiene

If Undar 1 Year

Months

Days

Certificate of Death

Physician /Medical

JAMES LOUIS COLLINS

Directo

Funeral

by

Completed

Be

1. Decedent's Name (First, Middle, Last) James Louis Collins

6. Sex ↑□ M 2□ F

2. Date of Death Month Day Year 19, 1998 AUG.

8. Data of Birth (Month, Day, Year,

October 1, 1920

3. Time of Death 2249 PM

Birthplace (State or Foreign Country)

Maryland

Black

Examiner

4a Facility Name (If not institution, give street and number) 42580 CLOVER HILL ROAD

HOLLYWOOD If Under 24 Hrs.

Hours

4b. City, Town, or Location of Death

4c. County of Death ST.MARY'S

Funeral Director

"natural", or items 23s or 28s-f show

Pages 1 and 2 should be filed within 72 hours atter and of Health and Mental Hygiene. and If Item 27 is marked other than "natural, or ite mry or other traumatic event, the Medical Examine.

permit. Page Department of Important: If any Injury or pnce.

Physiclan /Medical

Examiner

physician and s the burial-transit

attanding pl

signed by the aid to be datached for

been si

is certificate has t director, pege 2 s

funeral

2

Hospital or Attending Physicien: 24 hours after death.

Funeral Director: After this certifica

To the Hospital or within 24 hours aft To the Funeral Di completaly filled in

The law requires that the death certificate be axecuted

P.O. Box 68760

Records,

Division of Vital

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Examir

Physician/Medical

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Completed

Be

10

Certification:

edical

altimore, Maryland 21215-0020

the Maryland

death with

Usual Rasidence of Decedant 10a. State Maryland

10b. County St. Mary's

10c. City. Town or Location Hollywood

7. Age (In yrs. last birthday)

77

10d. Inside City Limits 1 Yas 2 No

10e. Street and Number

5. Social Security Number

213-22-1470

10f. Zip Code 20636 10a. Citizen of What Country? U.S.A.

42580 Clover Hill Road

1 Never Married 2 Married 3 Widowed 4 Divorced

12. Was Decedent Ever in U,S. Armed Forces? 1∑ Yes 2 □ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Ricen, etc.) 1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

15. Decedent's Education (Specify only highest grade completed)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

Specify.

Elementary/Secondary (0-12) 8th

College (1-4or 5+)

Laborer

Construction

17. Father's Nama (First, Middla, Last)

John Lewis Collins

Mary Agnes Neal

19a. Informant's Name/Relationship (Type, Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10813 Joyceton Court, Upper Marlboro, MD 20774

Mattingley-Gardiner Funeral Home, P.A.

18. Mothar's Name (First, Middle, Maiden Surnama)

John E. Queen/Son

20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from Stata

20b. Place of Disposition (Name of cemetery, crematory or other place)

Data 20c. Location - City or Town, Stata

4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee

Queen of Peace Cemetery 22. Name and Addrass of Facility 8/25/98 Helen, Maryland

Harde luc 23a. Part1. Enter the disease or complications that caused the shock, or heart failure. List only one cause on each line.

P.O. Box 270, Leonardtown, Maryland 20650 onct enter the mode of dylng, such as cardiac or raspiratory arrast,

Approximata Intarval Batween Onset and Death

Immadiata Causa (Final disease or condition resulting in death)

Due to (or as a consequence of):

Due to (or as a consequence of)

Dua fo (or as a consequanca of).

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significent conditions contributing to death but not resulting in the underlying causa givan in Part I.

23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performad? Yes 2 No 24b. Were autopsy findings available prior to complation of ceuse of death?

26. Place of Death (Check only one)

Yes 2 No

25. Was cese referred to medical XX Yes 2 No

27. Manner of Death

1 Natural

2 Accident 3 Suicide 4 Homicide

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 5 Pending

28b. Time of Injury Fred 1/19/98 2249 28c. Injury at Work? 1 Yes

Other: 4 Nursing Home AResidence 6 Other (Specify) 28d. Dascribe how injury occurred ets boys

29a. Certifier

28e. Place of Injury - At home, farm, streef, factory, office building, etc. (Specify)

Sulp Location City or To (Streat and Number of Town, State) And Holly to Clorge (tel mondelle

(Check only one)

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and mannar as stated. (

Medicel Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated.

29b. Signatura and title of certifier

29c. License number O.C.M.E

111 Penn Street, Baltimore, Maryland 21201

29d. Date signed (Month, Day, Year) AUG. 20, 1998

30. Name and addrass of person who complated ceuse of daath (Itam 23a) (Type, Print)

investigation

6 Could not be datarmined

TEXPERE Miking 31. Date filed (Month, Day, Year) AUG 2 4 1998

Registrar's Signature

souks

State Registrar

FOR THE DIST. Care Control of the C or sale-5 - F-20 - H Service of the servic ALL THE PLANTS The state of the s

7

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

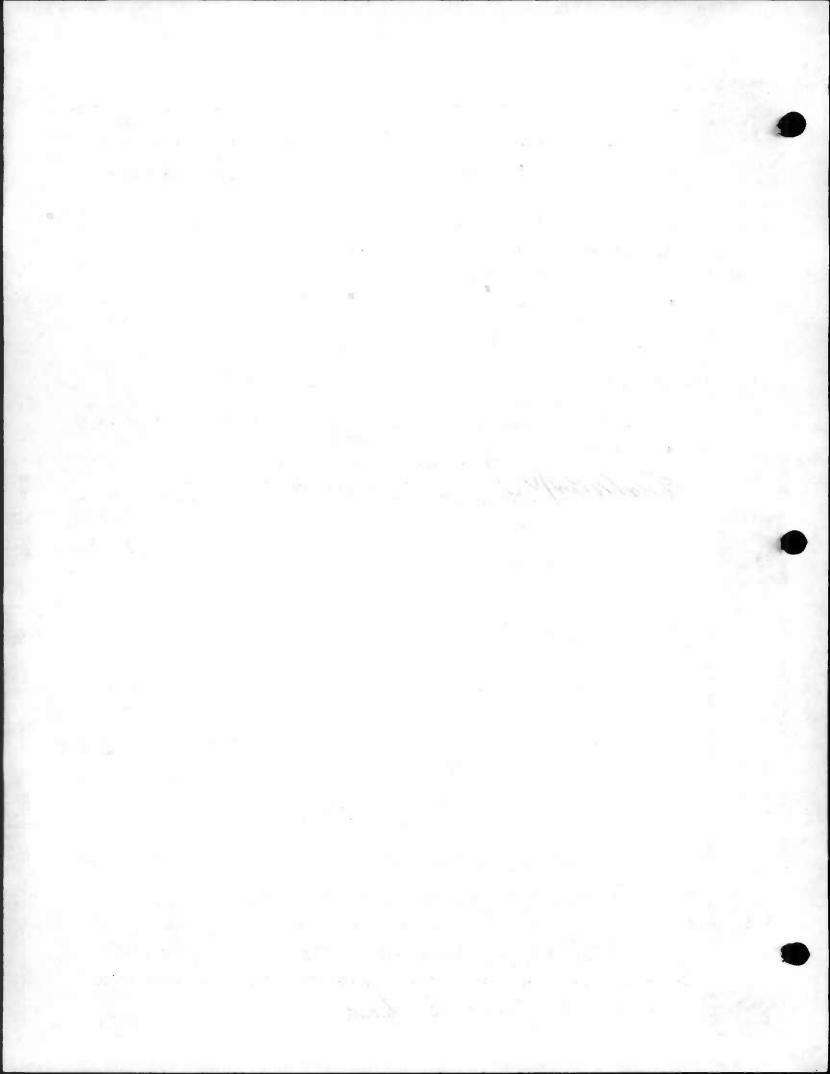
SARAH LOUI			(First, Middle, La	ef)		Certifica	te of	Death	2. Date of D	Reg. No.		3. Time of Death
Physiciar				se Collin	S				Month	Day	Year	
/Medica Examine	4a Fecili	ty Name (If		e street and numbe				4b. City, Town, C	AUG. or Location of Dea	th 4c. Co	.998 unty of Death MARY 19	
Funeral Director		Security Nu		Sex 7. A	ge (In yrs. last bii 74	thday) If Under Months	r 1 Yeer Deys	If Under 24 H Hours M		irth ay, Year) 1924	9. Birth Cou Mar	place (State or Fore intry) 'y land
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d within 72 hours aft giene. or than "natural", or the Medical Exer-	Element 17. Father Jol	(Speci	15. Decedent's E- fy only highest gra dary (0-12)	ducation ade completed) College (1-40)	5+)	Decedent's Usu (Give kind of we life. DO NOT	ork done ise retire	during most of v d)	vorking		spital	
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pemit. Pag Depertmant Important: i any injury o	1	hic	hace of disease, or com	plications that cause one cause on each	anderes	P.O. 1	Box 2	270, Lec	er Funer nardtowr	, Mary		
Physician /Medical Examiner	Immedia disease resulting	ite Cause (For condition in death)	Final	a. Shot	Sin h				and N			Onset and Death
entificate be assected ding physician end se es the burial-transit	-	ially list con ading to imi Enter Under Disease or I ated events in death) L	ditions, mediate typing njury	b		consequence of)						
at the death cert d by the ettendin eteched for use	Part II. Of	ther signifi	cant conditions	ontributing to death	but not resulting i	n the underlying	cause giv	ven in Part I.	23b. Dio	i tobacco ua	contribute	to the causa of dea
									1	Yes 2 1	No 3□Pr	obably 40 Unkn
iden: The law requires that the death cer cartificate has been signed by the ettendirector, page 2 should be deteched for use	G page								24a. Wa	s an autopsy formed?	8	Vere autopsy finding vallable prior to completion of cause of death?
The law ata has be paga 2 s									1)	Yes 2□N		Yes 2 No
artific setor.	25. Was		ed to medical					26. Place of D	eath (Check only	one)		-1
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or Attending after death. Director: After in by the fune	27. Mann 1	ner of Death Natural Accident Suicide Homicide	5 Pending investigatio 6 Could not be determined	e 28e. Place of I	njury - At home, fa	A9 NX arm, street, facto		ry at rk? Yes 2 No	City or To	(Street and Nown, State)	hat	ral Route Number,
To the Hospital within 24 hours To the Funeral completaly filled	29a. Cer (Che	eck only	1☐ Certifying Pt	nysician: To the bes niner: On the basis end manner s	t of my knowledge of examination ar	e, death occurred d/or Investigation	at the ti	me, date and pla opinion, death oc	ice, end due to the courred at the time	ceuse(s)	d menner as aca, and due	stated. to the cause(s)
o the		nature and	itle of certifier	. ,		29	c. Licens	se number		29d. Date s	igned (Month	o, Day, Year)
->-0		The	Ine 4	thing.	wy		0.0	C.M.E		AUG.	20,	1998
	1	HEU	DORE MI	completed calls of			tree	et, Balt	imore, M	arylan	d 2120)1
State Registrar	31. Dete	filed (Month	2. 4. 1998		trar's Signature	Soon	60					

DHMH 16 Rev 6/95

Please

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e Type or Print in Black Indelible Ink. Ass State of Maryland / Department of Health	and Mental Hygiene 90 2/004
Certificate of Death	7 Reg. No.

Dhysisian		 Dacedent's Name (First, Middle, Last 	st)					2. Data of Do Month	eeth Day	Yaer	3. Tima of Deeth
Physician /Medical		Idomia	Chamber	s				August			1650
Examiner		4e. Fecility Nama (If not institution, give	a street end numbar)				4b. City, Town, o	or Location of Dee		of Daath	
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ad at		Usuel Residence of Decedent 10a. State 10b. County Maryland St. Mary		c. City, Town							10d. Inside City Limit
be notified Director	3	10e. Street and Number	y 5 C	allaw	10f. Zip	Codo			10- 00	14/h - 4 O	
rai Dir	2	20088 Piney Point	Road		206				10g. Citizen of United		-
netural, or terms 238 of 288-1 anow		11. Maritel Stetus 1 Never Merriad 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forcas? 1 ☐ Yes 2 ■ No If Yes, Give Yeer or Dates:	in U,S.	If Yes, spec	cify Cub	Hispentc Origin? ean, Mexican, Pud Specify:	(Specify Yes or No erto Rican, etc.)		ck, White,	can Indian, etc. Lack
ted la	3	15. Decedent's Ed	ucation	16e.	Decedent's Usua	1 Occu	petion during most of w	and the second	16b. Kind of B	usiness/In	dustry
		(Specify only highest green (0-12)	College (1-4or 5+)		life. DO NOT us Homema	se retire	ea)	vorking	N/A		
5 0	3	17. Fathar's Nama (First, Middle, Last) George Tillery						lame (First, Middle		na)	
term -		19a. Informent's Name/Relationship (7	Type, Print)	19b.	Mailing Address	(Strae	t and Number or	Rurel Route Numb	per, City or Town	, Stete, Zip	Code)
r traumatic ave		Phyllis Armstrong	, Daughter	18	10 Metze	rot	t Road,	Adelphia	a, Maryl	and 2	20783
any injury or other traumatic av	2	20e. Method of Disposition 1 Burlal 2 Cremetion 3	Removel from Stata	cemetery	Disposition (Nan v, cremetory or o	ther ple		Data	20c. Location	•	
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any l		Edward N. Brin		м00052	Brinsf	iel	ess of Facility d Funera Lywood R	1 Home, load, Leo	P.A. nardtow	n, MD	20650
		23a. Pert1. Enter tha disease, or comp shock, or heart failure. List only	olications thet caused the cone ceuse on each line.	daath. Do n	ot antar the mod	e of dy	ng, such as card	iac or respiretory a	arrast,	-	Approximata Intervel Between Onset end Deeth
ian ical	ŀ	Immadiate Cause (Finel	()								
ner	1	diseese or condition resulting in death)	0.	mach		eec					about me
je je			Due	to (or es e c	onsequence of):						month
Examiner		Sequantially list conditions, if any, leeding to immadiate cause. Enter Underlying	b. — Due t	to (or es e co	onsequence of):						
clan/Medical		Ceuse (Disease or Injury that Initiated events resulting in deeth) Lest	cDue t	o (or as a co	onsequenca of):						
for use es the buriel-trensit			d								
Physic Physic		Pert II. Other eignificant conditione co	intributing to death but not	resulting In	the underlying ca	ause gi	ven in Pert I.				o the cause of deat
by Pt								_ 1□	Yes 2□ No	3 Pro	bably 4 🗆 Unkno
completely filled in by the funeral director, page 2 should be detected Medical Certification: To Be Completed by Physic								24a. Wes	en eutopsy ormed?	av	ere eutopsy findings allable prior to mpletion of cause death?
8 E								10	Yas 22 No		∃Yas 2□No
Be C		25. Wes case referred to medical					26. Place of D	eeth (Check only			2010
To E		examiner? 1 ☐ Yes 2 ☐ No	Hospital:	2□ ER/Out	petient 3 DO	A Ott	oor:	Homa 5□Resi		ar (Specif	v)
ation:		7. Menner of Deeth 1 StNaturel 5 ☐ Pending 2 ☐ Accident investigation	28e. Dete of Injury (Month, Dey Year	28b. Ti		Bc. Inju Wo			how Injury occur		
Certification:		3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Sp.	At home, farr ecify)	m, street, factory	, office		28f. Location (City or To	Street end Numb wn, Stete)	er or Rura	al Route Number,
edical C		29a. Certifier 15 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my iner: On the basis of examend menner steted.	knowledge, nination end/	deeth occurred of or investigation,	t the ti	me, dete end pled opinion, deeth occ	ca, end due to the curred et the time,	cause(s) end me dete end place,	enner es s end due to	teted. the cause(s)
W	2	9b. Signature and title of certifiar		1.0	29c	Licens	sa number		29d. Date signe	d (Month,	Day, Year)
		Quit	for an a	2ahna	" " "	D	50044		08/25	1199	98
	3	O. Name and address of person who co		(Item 23e) (T	ype, Print)			lywood,	Marulan	1 206	36
Choke	3	11. Dete filed (Month, Dey, Year)	M.D. 240.		ee NOLC	II K	Jau, HOL	.rywood,	rarytano	1 200	70
State egistrar	ľ	AUG 2 5 1998	Se registrers Si	B.	Span	h					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth 13, 1998 4b. City, Town, or Location of Death ORIS CRUM 15:04 4e. Fecility Name (If not institution, give street end number) 4c. County of Death 6. Sex 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) University 5. Social Security Number Birthplace (State or Foreign Country) 1 M 2 D Yrs. 214-32-2680 67 Aug. 19,1930 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ◯ No Maryland Frederick Middletown 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? 4500 Pine Valley Ct. 21769 United States 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. Never Married 2 Married 1 ☐ Yes 2 No Il Yes, Give Year or Dates: 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondery (0-12) 9 none 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) glenn R. Crum Grace Ε. Wachter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Gynith Clark / friend 4500 Pine Valley Ct. / Middletown, Md. 21769 of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Piece of Disposition (Neme of cemetery, cremetory or other plece) Burial 2 Cremation 3 Removal Irom State 4 ☐ Donation 5 ☐ Other (Specify) Mount Olivet Cemetery 8-17-98 Frederick, Maryland 22. Name end Address of Facility Stauffer Funeral Home 21. Signature of Funeral Service Licenses 23a. Perf I, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. 1621 Opossumtown Pike/ Frederick, Md. Approximate Intervel Between Onset and Deeth Immediate Cause (Final 2 hours Ventucular Failur disease or condition resulting in death) Retical CORTIC Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Hupertension Due to (or es e consequence of): Dependent Diabetic Millyuitis 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown the perchale tralema 24b. Were eutopsy lindings evailable prior to completion of cause of death? 24e. Wes an autopsy performed?

Physician /Medical Examiner

pue

The law requires that the deeth certificate be executed

Box 68760,

P.O.

of Vital

Division

Physician

/Medical

Examiner

10e State

Funeral

Director

28a-f show

the

filed within 72 hours efter

21215-0020

Maryland

Baltimore,

Director

Funeral

þ

Completed

Be

7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Moores Examinat must be motined as

Hygiene.

Pages 1 end 2 should be filed in nent of Heaith end Mental Hygirint: If Item 27 is marked other

Depertment of Health el Important: If Item 27 is any injury or other trai

Examiner al or Attending Physician: The setter death.

I Director: After this certificated in by the funeral director, ps

signed by the e

certificate

n 24 hours of Funeral Di Hospitai

To the Hospi within 24 hou To the Funer completely fil

Physician/Medical à Completed Be (2 Medical Certification:

Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

1 Yes 2 No

1 Yes 2□ No

25. Was cese referred to medical examiner? 26. Piece of Death (Check only one) Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Deeth

28a. Dete of Injury (Month, Dey Year) 28b. Time of

28c. Injury et Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred

6 Could not be determined 28e. Place of Injury - At home, larm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

157 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the ceuse(s) and menner stated. 29b. Signature end title of certifier

5 Pending Investigation

29c. License number P06030 29d. Date signed (Month, Dey, Yeer)

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

e. Saum Kenneth 31. Date filed (Month, Dey, Year)

2 Accident

3 Suicide

29a. Certifier

4 Homicide

32. Registrar's Signature

w

M.D. LIMMS 22 S. GTUINE ST, BAILIMOTE. MD 21201

State Registrar

AUG 1 9 1998



MARIO COMPANIA COMPAN

State of Maryland / Department of Health and Mental Hygiene

	t. Decedent's Name (First, Middle,	ast)	U	ei iiiicall	e of Death	2. Date of Dec	Reg. No.	1 :	3. Time of Deeth
Physician	Pierce M. Dam					Month	Dey	Year	
/Medical	4e Facility Name (If not institution,				4b. City. Town, or	August Location of Deeth			7:58 a.m
Examiner	Laurel Regiona							e Geor	0010
			(In yrs. lest birthda	(av) If Under		8. Date of Birt			e (State or Foreign
rector	219-12-4721 Usual Residence of Decedent	1 M 2□ F	78 Yrs.	Months	Days Hours Min	June 27	7, 1920		ginia
MO NO	t0a. State 10b. County		10c. City, Town or	Location				10d.	Inside City Limits
al, or items 23a or 23a-f show Examiner must be notified at by Funeral Director	Maryland Prince	George's	Belts	sville					1 ☐ Yes 2 ☐ No
or 28a-f s be notfiled Director	10e. Street and Number			10f. Zip	Code		10g. Citizen of V	Vhet Country	?
Sa Ca	4912 Powder Mil	1 Road			20705		U.S.	Α.	
iner must. Funeral	11. Marital Status	t2. Was Decedent E Armed Forces?	ver in U,S. t	3. Was Deced	lent of Hispanic Origin? (3 ify Cuban, Mexicen, Puel	Specify Yes or No-	14. Rac	a - American k, White, etc	
edical Examine leted by Fu	t ☐ Never Married 2 ☐ Mamed		Fob 6 42		2 No Specify:	to rican, etc./			•
I by	3 X Widowed 4 □ Divorced	Year or Dates:	140 V . 20 , 50				Specify	Whit	e
any injury or other treumetic event, tre Madical Bodge. To Be Completed	15. Decedent's (Specify only highest)	Education prede completed)	16a. De	cedent's Usua	al Occupation ork done during most of wo se retired)	orking	16b. Kind of Bu		*
du	Elementary/Secondary (0-12)	College (1-4or 5	F)				U.S. De	_	ent Of
Co	12		Trac	ctor Op	erator Fore		Agricu		
Be	17. Father's Name (First, Middle, La	st)			18. Mother's Na	me (First, Middle,	Malden Sumam	10)	
2	Pierce M. Damew	ood				e Kerr K			
5	19a. Informant's Name/Relationship			ailing Address	(Street and Number or F	tural Route Numbe	er, City or Town,	State, Zip Co	ode)
th the	Karon C. Damewoo	d - Daughte			r Mill Road				
to L	20a. Method of Disposition t ⊠ Burial 2 ☐ Cremation 3	□ Removal from State	20b. Place of Discemetery, of	sposition (Nen cremetory or o	ne of ther plece)	Date	20c. Location -	City or Town	, State
n's	4 □ Donation 5 □ Other (Spe		Union Me	emorial	Cemetery	8/21/98	Burtons	ville,	Marylan
eny injury or pace.	21. Signature of Funeral Service Lic	ensee	1 ,		d Address of Facility				
6 8	1 Honola	15	asch	Gasch'	s Funeral Ho altimore Av	ome	++ arri 11	o MD	20781
	23a. Pert1. Enter the disease, or co shock, or heart failure. List or	mplications thet caused	the death. Do not	enter the mod	e of dying, such es cardia	ac or respiretory er	rest,		pproximete iterval Between
ian	shock, or heart failure. List or	ly one cause on each lin	θ.					i o	nset and Death
cal	Immediate Cause (Final		CORDI	VARY	sport .	NISTAS	3	11	MINS
ner	disease or condition resulting in death)	a							
ē	Due to (or as a consequence of): DIBETES MELLINS								DYRS
Examiner	D								
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edical	Cause (Disease or Injury that Initiated events resulting in death) Last	C	Due to (or as a cons	sequence of):					
2	The local war is	d							
by Physician/N	Part II. Other eignificant conditions	contributing to death bu	t not resulting in the	e underivina c	euse given in Part I.	23b, Dld 1	lobacco use co	ntribute to th	ne cause of death?
Physician/N				,,,,,,	g	10			bly 4 ☐ Unknow
by P					***************************************		,		
8						24a. Was	an autopsy		autopsy findings
Completed						репо	rmed?		oletion of ceuse
E						400	res 20 No		
	OF Was seen referred to madical					101	/	101	res ZINO
Be C	25. Was cese referred to medical examiner?	Hospital:			Other	eath (Check only o		40 41	
_	1 Yes 2 No 27. Mannar of Death	1 Inpatie	-		A 4 Nursing	Home 5 ☐ Resid	now Injury occur		
led in by the funera Certification:	1 Natural 5 ☐ Pending	(Month, Dey	Year) Injur	y M	8c. Injury at Work? 1 ☐ Yes 2 ☑ No	200. 2000	Total Injury Coods		
E Ca	3 ☐ Suicide 6 ☐ Could no	be on Dian of take	ry - At home, farm,		-	28f. Location (S	Street end Numb	er or Rurel F	Route Number.
- T	4 ☐ Homicide determine	building, etc		, , , , , , , , , , , , , , , , , , ,	,, (City or Tov	vn, State)		
0									
edical	29a. Certifier (Check only one) 29a. Medical Examiner: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as state (Check only one) 29a. Certifier (Check only one) 1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, end due to the and manner stated.								
completely filled in by the funeral Medical Certification:	29b. Signature and title of an order		1	290	c. License number		29d. Date signe	d (Month, De	y, Year)
5	////	Much	the .		D2409	2			
11	1 -1-4		~ -		10101	,	August	1/,	1998
Va	30. Name and address of person with				#107	1.7	1	20712	
~	Mark Parkhurst,			Avenu	e, #10/, Co	Tiege Pa	rk, MD	20740	
State	31. Date filed (Month, Day, Year)		r's Signature	1					

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day August 24, 1998 Eugene (NMN) Dillard 7:12 AM 4a Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Southern Maryland Hospital Prince Georges Clinton If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) March 9, 19 5. Social Security Number Birthplace (State or Foreign Country) 100 M 20 F Yrs. 229-42-7729 Virginia **Usual Residence of Decedent** 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2000 Maryland Prince George's Brandywine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10505 Cedarville Rd. L3-6 20613 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Merried 2 Merried 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 ☐ Yes 2 No White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Construction 8 Carpenter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kickle N. Dillard Sally Ann Mitchell 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Louise Dillard-Wife 10505 Cedarville Rd. L3-6, Brandywine, MD 20613 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) Date 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removel from State
4 Donation 5 Other (Specify) 8-28-98 Waldorf, MD Huntet Crematory oneral Sensor Licensee Huntt Funeral Home, Inc. David A. Goff M01095 Box 156, Waldorf, MD 20604-0156 23a. Pert1. Enter the disease, or complications the used the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, Approximate Intervel Between Onset and Death

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

mast be notified at

permit. Peges 1 and 2 should be filed within 72 hours after death v. Department of Health and Mentel Hygiens. Important: if frem 27 is marked other than "natural", or frems 29 and in Jury or other treumatic event, the Hedgel

Baitimore, Maryland 21215-0020

Director

Funeral

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Be Completed

2

with the Manyland

Physician/Medical Examiner ۶ م Be Completed Medical Certification: To

To the Mospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completaly filled in by the tunered director, page 2 should be detached for use as the burlie-transit

Division of Vital Records, P.O. Box 68760,

disease or condition resulting in death)	e Man	14 Ru	TUBIL USIS	11500	rosyl	Z4 KNONET
	Due to (or as e consequence o	f):			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events	Due to (or es e consequence o	f):			
that infleted events resulting in death) Last	Due to (c	or as a consequence of):			
Pert II. Other significant conditions of	contributing to death but not res	sulting in the underlying	cause given in Pert I.	23b. Did to		3 Probably 4 Unknown
					en autopsy med? 'es 2 No	24b. Were eutopsy findings available prior to completion of cause of death? 1 Yes 2 No
25. Was case referred to medical			26. Place of De	eth (Check only or	ne)	
examiner?	Hospitel: 1 Impatient 2	ER/Outpatient 3 1	DOA Other: 4 Nursing I	Home 5 ☐ Resid	lence 8 Ott	her (Specify)
27. Manner of Death 1	28a. Dete of Injury (Month, Dey Year)	28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe h	ow injury occur	rred
3 Suicide 6 Could not be determined		ome, ferm, street, fectory)	ory, office	28f. Location (S City or Tow		ber or Rural Route Number,
29a. Certifier (Check only one) 1 Certifying Pl	nysician: To the best of my known of the basis of examine end menner steted.	wledge, deeth occurre tion end/or investigation	d et the time, date end plac on, in my opinion, death occ	e, end due to the durred et the time, d	ause(s) and midate end plece,	enner es stated. end due to the cause(s)
29b. Signatury and title of certifier		2	9c. License number	2	29d. Date signe	ed (Month, Day, Year)
> Whored	Meril)		D24945	1	Tugus	1-24, 1998

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of pur

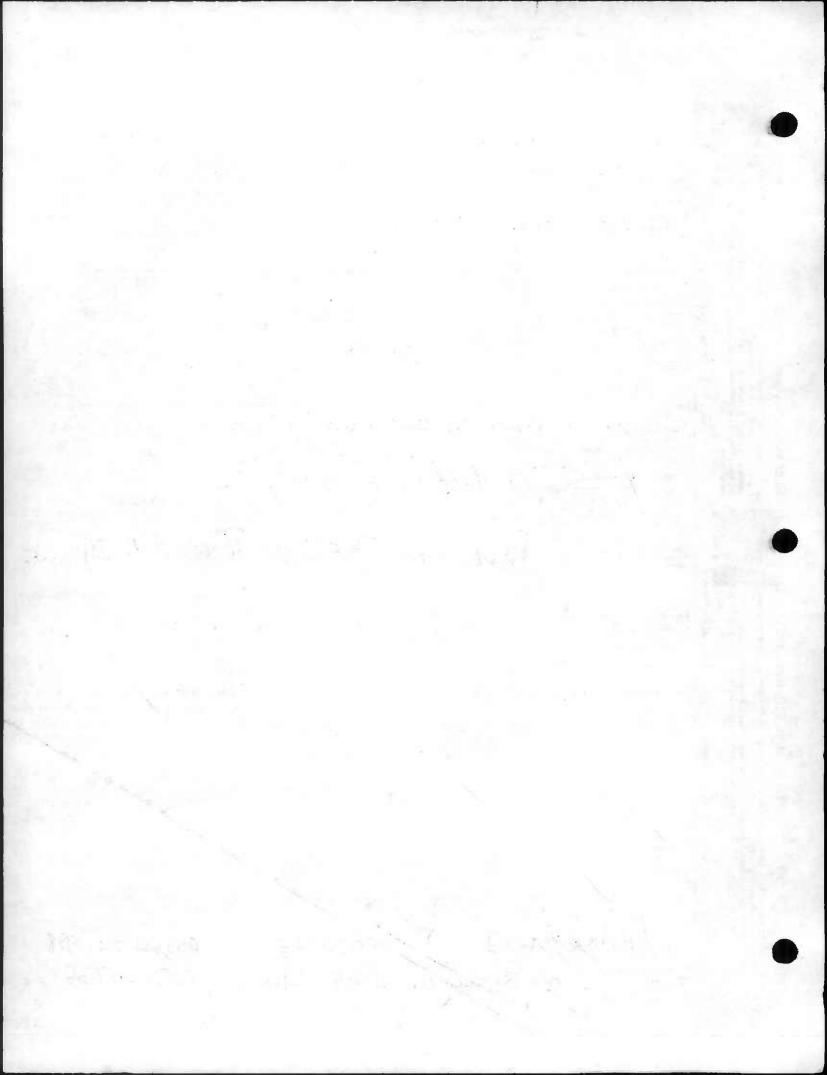
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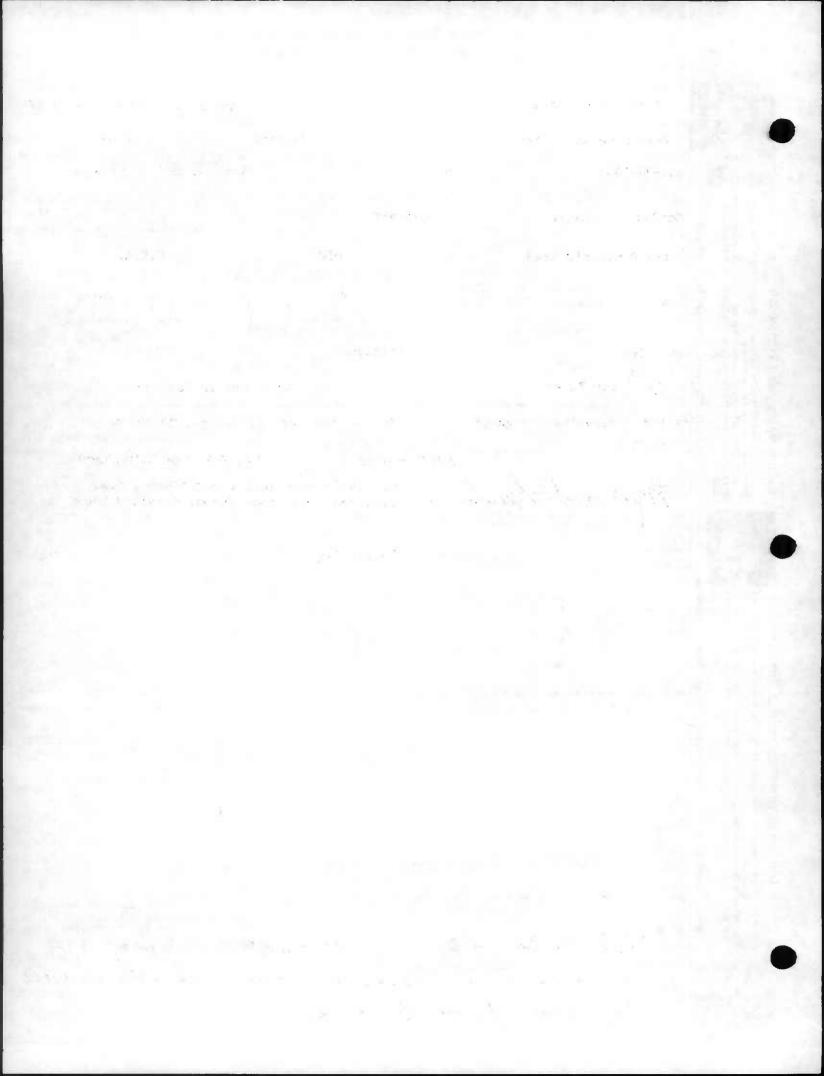
who completed cause of death (ftern 23a) (Type, Print)

INJON



State of Maryland / Department of Health and Mental Hygiene

				Cei	tificate of	Death			Reg. No.		
Dhysisian	1. Decedent's Nama (First, Midd						2	2. Date of Dec Month	Dav	Yaar	3. Time of Death
Physician /Medical	Mary Alice D	yson						August		998	4:15 AM
Examiner	4a Fecility Name (If not institution		umber)	- 17-17				ation of Death			
	2413 Pinefiel					Wald				arles	
Funeral Director	5. Social Security Number 4 31 – 30 – 5 2 2 1	6. Sex 1 □ M 2 □ F	7. Age (In yrs. 75	lest birthday) Yrs.	If Undar 1 Year Months Deys	If Under Hours	Min. M	B. Date of Birt (Month, De arch 12	y, Year) 1923	9. Birthp Coun Arka	lece (Stete or Foreign try) NSAS
p ,	Usuel Residence of Decedent		140- 0	ibi Tour or La						- 1.	Od basida Cibal India
Maryle and show	Maryland Char		100. C	ity, Town or Lo Waldo							0d. Inside City Limits 1 ☐ Yes 2 No
vith the Ma	10e. Street end Number				10f. Zip Code	10g. Citizen of Whet					itry?
h will	2413 Pinefield	Road			2060	0 1			U.S.	Α.	
In Z. I.Z. 15-0020 Ilied within 72 hours effer death with the Maryland Hydiona. Hydiona. In Medical Examiner must be notified at Completed by Funeral Director	11. Maritel Status 1 Never Married 2 Mar			J,S. 13.	Was Decedent of h f Yes, specify Cub	dispanic Origan, Mexican Specify:	gin? (Spec n, Puerto Ri	ify Yas or No- ican, etc.)	14. Rec Blac Specify	a - Americ ck, White, v: Wh	
ural'. o	34 Widowed 4 □ Divorced		Dates:	1					101 101 10		
72 in 72 in 72 in att	15. Deceder (Specify only higher	nt's Education est grade completed	1)	16e. Deced	dent's Usual Occup kind of work done DO NOT use retire	during mos	t of working	9	16b. Kind of B	usiness/ind	dustry
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should be and Mental or merked or umetic even	Joe Darby Es	tes				Ma	yme M	rytle	Henders	on	
M 2 Drd 2 stranger trans	19a. Informent's Name/Relation: Mary P. Chappel		ter		ng Address (Street Crestwo						Code)
Health Health other tr	20a. Method of Disposition				sition (Neme of netory or other pla			Date	-		own, State
Dealtimore, permit. Pages 1 at Department of Hea Important: if item; any Injury or other once.	1 Burial 2 Cremation 4 Donation 5 Other (5		II State	ly Face (Cemetery				/98 Great Mills, Maryland		
Depart Import Import Instance	4 Donation 5 Other (Specify) Holy Face Cemetery 8/29/98 Great Mi 21. Signifure of Funeral Service Licenses Mattingley-Gardiner Funeral Home P.O. Box 270, Leonardtown, Maryl										
Physician	23a. Part1. Enlar tha disaase, o shock or heart failure. Lis	r complications that t only one cause on	causad tha daa eech line.								Approximate Interval Between Onset end Deeth
/Medical	Immediate Cause (Finel disease or condition		LUNG	, (ANCER						6 mo.
Examiner	resulting in death)	θ		or as e consec							
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deeth c											
. 0 0 0	Part II. Other significant conditi	ons contributing to	death but not res	sulting in the u	ndarlying cause gi	ven in Part I		23b. Did	tobacco uee co	ntribute to	o the causs of death
			-					10	Yes 2 No	3 Pro	bably 4 Unknow
Physician: The law requires that the this certificate has been signed by the rei director, page 2 should be datached. To Be Completed by Physics								24a. Wes	en autopsy rmed?	av	ere autopsy findings allabla prior to impletion of causa
hes ge 2 ge 2 mpl									V.		deeth?
S S S S S S S S S S S S S S S S S S S								10	Yes 2 No	11	☐Yes 2☐No
Physician: The I	25. Was case raferred to medical examiner?	Hospital:				hon		(Check only o			
physic et direction To	1 Yes 2 No	1 1		ER/Outpetier	TI 3LI DOA	4 L NU	-		denca 6 □Oth		5/)
o ffe o	27. Menner of Deeth 1. Neturel 5 □ Pendi		e of Injury onth, Dey Year)	28b. Time of Injury		ry et		od. Describe	how injury occur	reu	
tal or Attending P is eftar deeth. al Director: After led in by the funer. Certification:	2 Accident investigation 3 Suicide Could not be determined 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)							28f. Location (Street end Number or Rural Route N City or Town, Stete)			al Route Number,
UNISION To the Hospital or Attending I within 24 hours staff adeals. To the Funeral Director: After completely filled in by the funeral Medical Certification	29a. Certifier 12 Certifyi (Check only one)	ng Physician: To the Examiner: On the end ma	ne best of my kno basis of examina inner steted.	owledge, deatl ation end/or In	n occurred et the ti vestigation, in my	me, date an opinion, dea	nd place, er occurred	nd due to the d et the time,	ceuse(s) end m date end plece,	enner es s and due te	steted. the cause(s)
ithin of the omple	29b. Signeture and title of cartific		3.0.04.		29c. Licen	se number			29d. Date signe	d (Month,	Dey, Year)
F ≤ F ŏ	Mahi 1	falle	MD		D5	522	89		8/2	(6)	1998
(D)	30. Name and address of person NALIN MATI	who completed cau	use of death (Ite	m 23a) (Type, MBR.00	Print) KE SB.	SUITE	= 104	WA	ALDOR	FA	1D 20603
State Registrar	31. Date filed (Month, Day, Year AUG 26) 32.	Registrar's Sign		Spark						



KENNETH W. DEARSTINE

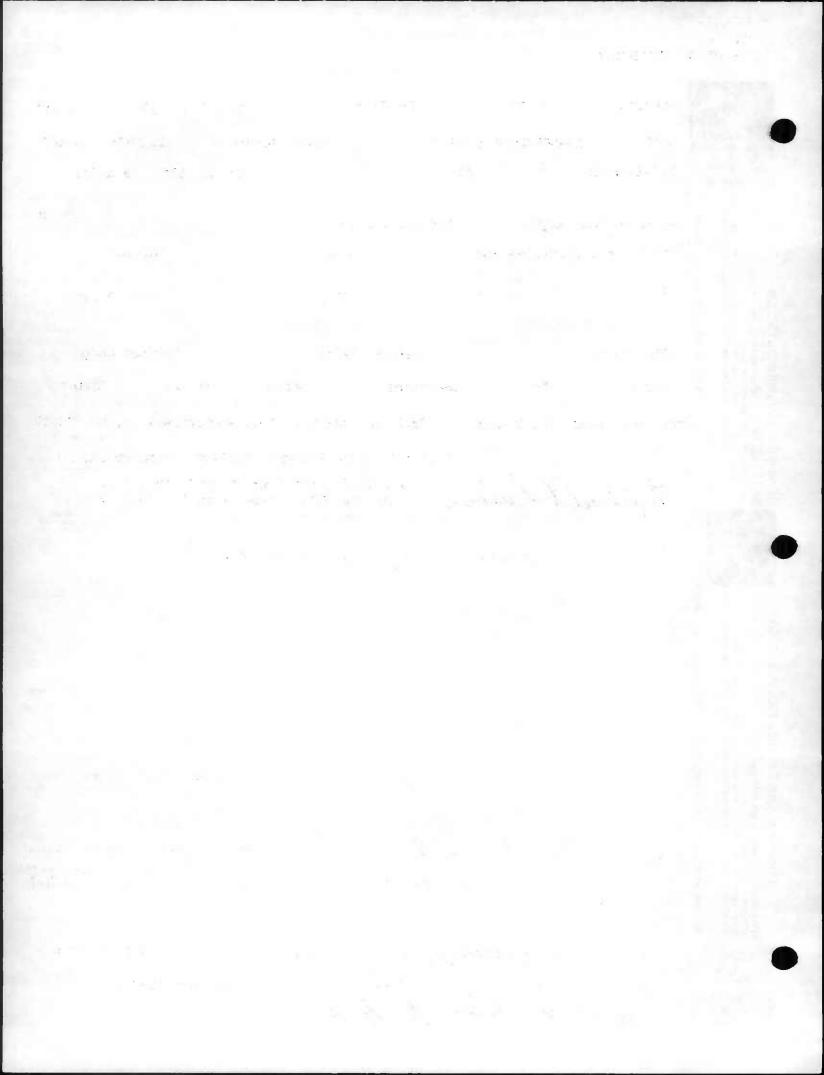
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State	of Maryland	/ Department	of Health	and Mental	Hygiene
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ian	1. Decedent's Nama (First, Middle, I						2. Date of Da Month	ath Day	Yaar 3.	Time of Deal
cal	Kenneth	Warren		Dears			AUGUST	27, 199	8	0812AM
ner	4a Facility Nama (If not institution, g	giva street and numbe	or)			4b. City, Town, o	r Location of Daatt	h 4c. County	of Death	
	26252 SOUTH SAND	DGATES ROAL	D-YARI		l I	MECHANIC			MARY'S	COUNTY
		. Sex 7. A 1 M 2 □ F		ast birthday)	If Under 1 Yaar Months Days	If Undar 24 Hi		th ly, Year)	9. Birthplace Country)	(State or For
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-	10a. State 10b. County		10c. City	, Town or Lo	cation					Inside City Lin 1 ☐ Yes 2🔀
e c	Maryland St. Mar	ry's	Med	chanic	sville					190
Oire	10e. Street and Number				10f. Zip Code			10g. Citizan of		
<u>a</u>	26252 South San	dgates Roa	nd .		2065	9		U.S	. A.	
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F	1 Never Marriad 2 Married	1 Yes 2 S	₫ No		I ☐ Yes 2⊠ No			Specif		-0
d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates	5:					0,000	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
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ig.	Elementary/Secondary (0-12)	College (1-4o	r 5+)					~		
S	12th Grade			Cabi	net Make				et Shor)
Be	17. Fathar's Name (First, Middle, La						ame (First, Middle			, .
2	Warren	Lee	Dear	rstine		Agnes	Be	ertha	Gra	abis
	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	ng Address (Street	t and Number or	Rural Route Numb	er, City or Town	, State, Zip Coo	de)
	Warren L. Dearst	ine/Father				gates Ro	d., Mecha	nicsvil	le, MD	20659
	20a. Method of Disposition		~	ace of Dispos	sition (Name of natory or other pla	ice)	Data	20c. Location	- City or Town,	Stata
	1 ☐xBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		Cha:	rles M	emorial	Gardens	8/31/98	Leona	rdtown,	MD
	21. Signatura of Funeral Service Lic	censee		M22	Name and Addra	ass of Facility	er Funera	1 Homo	D A	
	Michaela	Bride					nardtown,			550
	23a Part I Enter the disease or co	implications that caus	ed the death							
	23a. Part (Enter the disease, or conshock, or heart failure. List on	ly one cause on each	Lima			ng, such as card	lac or respiratory a			
			iline.		or the mode or dy	ng, such as card	ac or respiratory a	irrest,	Inte	erval Batwas set and Dea
	Immediate Cause (Final								Inte On	erval Batwaa set and Dea
	Immediate Cause (Final disease or condition resulting in death)	a. Contac	ct s	notqu	in Wou				On	erval Batwaa set and Dea
er	disease or condition		ct s		in Wou				On	erval Batwaa set and Dea
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Registrar

AUG 3 1 1998



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Dete of Deeth 3. Time of Death 20,1998 **Physician** Elizabeth Dorothy ERNEST 5:11 am August /Medical 4a. Facility Nema (If not institution, give streat and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5931 Bartonsville Road Frederick Frederick If Undar 1 Year If Under 24 Hrs. 8. Data of Birth Feb. 16,1922 5. Sociel Sacurity Numbar 9. Birthpiace (Steta or Foraign Mary Tand 7. Age (In yrs. lest birthday) **Funeral** Months Hours 219-14-8573 1 M 2 F 76 Yrs. Director Usual Rasidanca of Dacadant the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "naturel", or Items 23e or 28a-f show traumatic event, the Med cal Examiner must be neithed at Maryland Frederick Frederick 1 Yes 2 No Director 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 5931 Bartonsville Road 21704 permit. Pages 1 and 2 should be filled within 72 hours after death w Department of Health and Mental Hygiene. Important: If them 27 is marked other than "neturel", or items 23e any Injury or other traumatic event, the Medical Exercises 23e any Injury or other traumatic event, the Medical Exercises 23e any U.S.A. Funeral 12. Wes Dacedent Ever in U,S. Armed Forces? 1 ☐ Yas △2⑤ No If Yas, Giva Year or Datas: 13. Wes Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, White, atc. 1 Never Marriad 2 Married Baltimore, Maryland 21215-0020 1 □ Yas XX No Specify. Specify: White 3 ₩idowed 4 □ Divorced þ Completed 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highest grada complated) 16b. Kind of Businass/Industry Elamentary/Secondary (0-12) Collega (1-4or 5+) Homemaker Own Home 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Surname) Be William . KLINE Lillian UNKNOWN To 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Mrs. Carol L. Stillions, Daughter 1503 Taney Avenue, Frederick, Maryland 21702 20a. Method of Disposition
AC Burial 2 Cremation 3 Ramoval from Steta 20b. Placa of Disposition (Nama of 20c. Location - City or Town, Stete Dete Frederick Memorial Park, Aug. 24, 1998 Frederick, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nome and Addrass of Facility
Keeney & Basford P.A. Funeral Home
106 East Church St, Frederick, Maryland 21701 21. Signatura of Funeral Sarvica Licansaa MO0255 23a. Part1. Enter the disease, or complications that caused the deeth. Do not anter the mode of dying, such as cardiac or respiretory arrast, shock, or heart failure. List only one cause on each line. Approximate Intarvai Batwean Onset and Deeth Physician /Medical Immadiata Causa (Final disaasa or condition rasulting in daath) Congestive Heart Failure Years Examiner Dua to (or as a consequence of): Examiner Arteriosclerotic Cardiovascular Disease The law requires that the death certificate be executed Sequantially list conditions, if any, laeding to immadieta cause. Enter Undartying Ceusa (Disaase or injury that initiated events rasulting in daath) Last attending physician and for use as the burial-tran Due to (or es e consequance of) P.O. Box 68760. Physician/Medicai Dua to (or as a consequence of) USB BS Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 1 | Yes 2 | TNo 3 | Probably 4 | Unknown signed l Records, p 24a. Was an autopsy performed? 24b. Ware autopsy findings eveilable prior to complation of causa of daath? Completed peen page 2 s certificate 1 ☐ Yes 2 No 1 □ Yas 2 □ No Division of Vital To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, t Be 25. Was casa refarred to medical 26. Placa of Daath (Check only ona) Othar: 4 Nursing Homa 5 Rasidanca 6 Other (Specify) Certification: To 1X Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of 28d. Dascribe how injury occurred 28c. Injury at Work? 5 Panding Invastigation 1X Natural 1 ☐ Yas 2 ☐ No 2 Accidant 3 ☐ Suicida 6 Could not be 28a. Placa of Injury - At home, tarm, streat, fectory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 4 Homleida Medicai 1 Cartifying Phyaician: To tha best of my knowladge, death occurred at tha tima, dete end place, and dua to tha causa(s) and manner es steted.

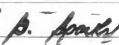
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) end manner stated. 29a. Cartifian 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Dey, Year) D35164 August 20, 1998 of death (Item 23s) (Type, Print) MD, Andrew Zarick, Jr, 1080 West Patrick Street, Frederick, Maryland 21703

State Registrar

AUG 2 1 1998

31. Date filed (Month, Day, Yaer)





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CASA STATE OF THE STATE OF THE

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth Month 8 5.05 pm. 4a Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Nursing Con 100
P. Age (In yrs. last birthday)
Yrs. Green be It Prince Green belt Georges 9. Birthplece (State or Foreign Country) 6. Sex 5. Social Security Number 8. Dete of Birth (Month, Day, Year) 1□ M 20 F Months Deys Hours Min. 578-24-9320 Usuel Residence of Decedent 4-20-1907 Mary land 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No MD. Prince Grorges Greenbelt 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 207 70 14. Raca - American indien, Bleck, White, etc. 7010 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No if Yes, Give Year or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Stetus 1 Never Merried 2 ☐ Married 1□ Yes 2 No Specify: White Specify: 3 Widowed 4 □ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Manutacturing Co. Operator 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) William Francis Mattingly Floyd -oulse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3008 Enterprise Son Rd. Mitchellville InD 20721 Clarence 20a. Method of Disposition

1 Burial 2 A Cremation 3 Removel from State 20b. Plece of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete Crematory Metropolitan 4 Donation 5 ☐ Other (Specify) 21. Signatore of Fundant 3 22. Name end Address of Fecility Gasch's Funeral Home Do not enter the mode of dying, such es cardiac or respiratory entest,

Approximate

Approximate Approximete Interval Between Onset end Deeth 23e. Pert1. Enter the disease or complications that cause of shock, or heart failure. List only one cause on each limit immediete Cause (Finel Congestive disease or condition resulting in deeth) Heart days Heart theroclerotic Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initieted events resulting in death) Lest Due to (or es e consequence of): Diabetes Mellitu years Anemia years holesterd 10 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24e. Wes en eutopsy 2 No 1 🗆 Yes 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Naturel

Division of Vital Records, P.O. Box 68760

sician end burial-transit requires that the death certificete be executed attanding physician for usa as the buria USB BS I signed by the a peen pega 2 certificate funeral director. this After

Physician

Examiner

Funeral

Director

7 is marked other than "natural", or Rems 23a or 28a-f shor treumstic event, the Medical Examinar must be notified at

other

permit. Pages Department of important: If it eny injury or c

Physician /Medical

Examiner

Examiner

Pages 1 and 2 should be filed within 72 hours after on nant of Health end Mantel Hygiane. ant: If Item 27 is marked other than "natural", or Ite

Baltimore, Maryland 21215-0020

the Maryla

death with

/Medical

10a. Stete

Director

by Funeral

Completed

Physician/Medical Completed by or Attending Physician: Be Certification: To 24 hours after death. completely filled in by Hospital

Medical To the I within 2

State Registrar 3 Suicide

29a. Certifier (Check only one)

29b. Signs

4 Homicide

5 Pending investigetion 2 Accident

6 Could not be determined

28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)

1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

12 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner es steled.
2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

D04483

30. Name end address of person tho completed cause of deeth (Item 23e) (Type, Print)

TIll Bergemann, 31. Date filed (Month, Day, Year) Centerway Rd. Greenbelt MD 20770 32. Pegistrer's Signature

AUG 1 7 1998

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 1. Decedent's Nama (First, Middla, Last) 3. Time of Death :20pm SALLIE SARAH FURNESS 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, giva street and number) ov + LUOS Nington + ince Crears If Under 24 Hrs. | 8. Data of Birth Hours | Min. | 8. Data of Birth (Month, Day, Year) | 9. Birthplace (States Foreign Country) Fort Washington 5 Social Security Number 4. Sax Hosporta 9. Birthplace (State of Foreign Country) 7. Age (In yrs. last birthday) Days 1 ☐ M 2 🛣 F Months Yrs. FEB 15,1914 247-28-8972 South Carolina Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 □ No Maryland Prince Georges Ft. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9003 Mill Street 20744 United States 12. Was Decedant Ever in U,S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 ☐ Yas 2 No If Yes, Give Year or Dates: 1 Never Marriad 2 Married 1 ☐ Yes 2X No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housekeeper Private 18. Mother's Name (First, Middle, Maidan Sumama) 17. Father's Name (First, Middle, Last) John Laurence Wilson Josephine Eaddy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) / Husband 9003 Mill Street, Ft. Washington, Md. 20744 Robert Furness 20a. Method of Disposition 20b. Place of Disposition (Name of cematary, crematory or other place) 20c. Location - City or Town, Stata Date 1 Burial 2 Cramation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Troy Funeral Home 8/13/98 Mullins, So. Carolina 21. Signature of Funeral Service Licenses 22. Name and Address of Facility ALEXANDER S. POPE FUNERAL HOMES M859 5538 Marlboro Pike, Forestville, Md 20747 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final disaase or condition resulting in death) Premain Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? 1 Yes 3 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 28. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)

Division of Vital Records, P.O. Box 68760,

thet the death certificate be executed

physician end s tha buriel-transil signed by the e s cartificata has b director, pege 2 s Hospital or Attending Physician: Aftar this after death. Director: Aft 24 hours a

Physician

/Medical

Examiner

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Funeral

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Completed

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7 is marked other than "natural, or items 23a or traumatic event, the Medical Examiner must be

the Maryland

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Pages 1 and 2 should be in nent of Health end Mantel I

Item 27

Important: If It any Injury or

Physician /Medical

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Certification:

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completely To the I

Registrar

29b. Signature and title of certifian

29c. Licensa number 1)45 365

1🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and dua to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and placa, and dua to the cause(s) and manner stated.

29d. Date signad (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WAShington

Anzertal 1/711 Liverity Rd follows nel

31. Date filed (Month, Day, Year) AUG 1 7 1998

4 Homicide

(Check only one)

29a. Certifier

32. Registrar's Signature

AUG 1979 B. BERT COUL

odo Wari o un Victor

Minchael Andre Fleet 46 Feelity Name (if not institution, plus street and number) 9218 D'Arcy Road 3. Social Security Number: 3. Social S	3. Time of Deeth 9:10 Am
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Toe. Street and Number Prince George's 10c. City, Town or Location Upper Mariboro 10d. Street and Number 9218 D'Arcy Road 10f. Zip Code 20774 10g. Citizen of Wing Specify Citizen o	Birthplece (State or Foreig Country) Maryland
10. Street and Number 9218 D 'Arcy Road 11. Maritel Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 11. Yes 20 No 11. Yes 20 No 11. Yes 20 No Specify: 15. Decedent's Education (Specify or highest grade configer) 15. Decedent's Education (Specify or highest grade configer) 16. Decedent's Usual Occupation 17. Father's Neme (First, Middle, Last) 18. Mother's Neme Relationship (Type, Print) 19. Informent's Neme Relationship (Type, Print) 19. Informent's Neme Relationship (Type, Print) 20. Method of Disposition 19. Method of Disposition (Name of ADD Print) 21. Signeture of Functions = Configer) 22. Name and Address of Fecility 23. Part I. Enter the diseased or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest. 10. Other significant conditions. 10. Sequentially list conditions. 10. Sequentially list conditions. 10. Sequentially list conditions. 10. Sequentially is condition. 10. Sequentially list conditions. 11. Sequentially list conditions. 12. Sequentially list conditions. 13. Sequentially list conditions. 14. Sequentially list co	10d. Inside City Limit
9218 D'Arcy Road 20774 11. Martiel Status 11. Am Be Decedent Erver in U.S. Am Be Decedent of Hispenic Origin? (Specify Yes or No- Ill Am Beautiful Status In Ill Yes 2 Ill No Ill Yes 2 Ill	1 DXYes 2 □ N
Armed Forces 1 1 2 2 2 No 2 No 2 No 2 2 No	et Country? USA
Elementary/Secondary (0-12) College (1-4or 5+) Laborer	American Indien, White, etc. Black
18. Mother's Name (First, Middle, Last) Shirley Louise Flee	ness/Industry
19a. Informent's Neme/Relationship (Type, Print) Carrie Fleet/Grandmother 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, S 9218 D'Arcy Road, Upper Marlboro, MD 20e. Method of Disposition % Burial 2 □ Cremation 3 □ Removel from State 4 □ Donelion 5 □ Clint (Specify) 21. Signeture of Funeral Service Licensee 122. Name end Address of Fecility 123. B. Jenk in S Funeral Home 7474 Landover Road, Landover, Mar 23a. Part1. Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, 13b. Due to (or as a consequence of): 25c. Was case referred to medical examilier? 15c. Was case referred to medical examilier? 16c. Place of Deeth (Check only one) 26c. Place of Deeth (Check only one) 27c. Name end Address of Fecility 27c. Name end Address of Fecili	
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examiner? 1 Yes 2 No Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home St Residence 6 Other	1□Yes 20 vo
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27. Manner of Death 1 Naturel 5 Pending (Month, Dey Year) 2 Accident investigation 28e. Date of Injury (28b. Time of Injury Work? 1 Yes 2 No 28d. Describe how injury occurre	
3 Suicide 4 Homicide 6 Could not be determined 28e. Plece of Injury - At home, term, street, fectory, office building, etc. (Specify) 28e. Plece of Injury - At home, term, street, fectory, office City or Town, Stete)	or Rural Route Number,
29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the ceuse(s) and man end on investigation, in my opinion, deeth occurred at the time, date and piece, and man end menner steted.	er es stated
Chambridge.	
30. Name and address of person who completed cause of death (item 230) (Type, Print) Richard Ambin Jer, 4(8 N, Bond S) Bhas the plains On to Lie	

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death **Physician** VirginiaFLAUTT HAZEL **AUGUST** 16, 1998 7:23 AM /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Memorial Hospital Frederick Frederick If Undar 24 Hrs. If Undar 1 Yaar 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Yaar) Birthplaca (Stata or Foraign Country) **Funeral** Days Months Hours 157-01-1574 86 Feb 11, 1912 Maryland Director Usual Rasidanca of Decedant with the Marylend 10a. Stata 10b. County 10c. City, Town or Location 10d. fnsida City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 XYas 2 □ No Maryland Frederick Frederick Director 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Coda 315 Rockwell Terrace 21701 U.S.A. Funeral Peges 1 and 2 should be filed within 72 hours efter death nent of Health and Mentel Hygiene. Int: If Item 27 is marked other than "natural", or itema 23 Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, etc. 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Giva 1 ☐ Navar Married 2 ☐ Marriad Baltimore, Maryland 21215-0020 White 1 ☐ Yas 2 🛣 No Spacify: Specify: À 3 Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decadant's Education (Spacify only highast grada complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collage (1-4or 5+) Homemaker Own Home traumetic event, 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) Be Benjamin Franklin RIGLER Sarah Virginia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Mrs. Sarah A. Surin/Daughter 315 Rockwell Terrace, Frederick, Maryland 21701 other i 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Data 0 1 XBurial 2 ☐ Cramation 3 ☐ Removal from Stata permit. Pege Depertment of Important: If any injury or once. Mount Olivet Cemetery Aug 19,1998 Frederick, Maryland 4 Donation 5 Other (Specify) 22. Nama and Address of Facility
Keeney & Basford P.A. Funeral Home 21. Signature of Funeral Service Lice M00706 106 East Church St, Frederick, Maryland 21701 Entar to isaase, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, or he of failure. List only one cause on each line. Approximata Interval Batween Onset and Daath **Physician** /Medical Immediate Cause (Final Pulmonary Ob structive disaasa or condition rasulting in death) Examiner Dua to (or as a consequence of) Examiner Pulmoinale thet the death certificate be executed Sequantially list conditions, if any, laading to immadiata cause. Enter Underlying Causa (Disaasa or injury that initiated avants rasulting In daath) Last physician end the buriel-tran Dua to (or as a consaquanca of): P.O. Box 68760, Physician/Medical Dua to (or as a consequance of): 98 950 0 23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed by the should be deteched 15 Yes 2 No 3 Probably 4 Unknown Records, p The law requires 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed certificate has director, page 2 2 No 1 Yas 1 ☐ Yas 2 ☐ No Division of Vital Physician: Be 25. Was casa referred to medical 26. Placa of Daath (Check only one) Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 10 1 Yas 2 No 1 Inpatiant 2 ER/Outpatiant 3 DOA this funeral 27. Mannar of Death Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Dascribe how Injury occurred 28b. Tima of Certification: or Attending P efter death. Director: After t 5 Pending invastigation fnjury 1 Natural 1 ☐ Yas 2 ☐ No 2 Accidant 3 Suicida 6 Could not be datarminad Place of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) completely filled in by 4 Homicida 24 hours e 29a. Cartifian 🄁 Certifying Physician: To tha best of my knowledge, daath occurred at tha tima, data and placa, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Vithin 2 29d. Data signed (Month, Dav. Year) 29b. Signatura and title of cartifiar 29c. License number Tole MD 8-16-98 MO0 5160 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Aue 1475 TO. Ney Suite 31. Data filad (Month, Day, Yaar) .32. Registrar's Signatura State **AUG 1 7 1998**

Registrar

4661 4 7 9AP

State of Maryland / Departmen	t of Health	and Mental	Hygiene
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Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath 3. Time of Death **Physician** Month Janet. Gilliam Aug. 13 1998 11:38a.m. /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11146 Wood Elves Way 7. Aga (In yrs. last birthday) Columbia Howard If Undar 1 Yaar If Undar 24 Hrs. 8 Data of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number Birthplaca (Stata or Foreign Country) **Funeral** Days 1 M 2 XF Yrs. 233-44-2038 Director Sept. 10, 1932 WV Usual Rasidence of Dacedant permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantel Hyglens. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Mod call Examinet inval be notified at once. 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits MD Howard Columbia Director 1 Yas 2 No 10e. Straat and Number 10a. Citizan of What Country? 10f. Zip Coda 11146 Wood Elves Way Funeral 21044 USA 12. Was Dacadant Evar in U,S. Armed Forcas? 13. Was Dacedant of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Race - Amarican Indian, Black, Whita, atc. 1 Nevar Married 2 Marriad 1 ☐ Yas 2 ▼ No if Yas, Giva Yaar or Datas: Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: by Specify: Black 3 ☐ Widowad 47 Divorced Completed 16e. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elementary/Secondery (0-12) College (1-4or 5+) D.C. Public Schools 4 yrs. Teacher 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Sumama) Be 2 Unknown Wannie Sue Scales 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Numbar or Rurel Routa Number, City or Town, Steta, Zip Coda) 11146 Wood Elves Way, Columbia, Md. 21044 Juliet N. Gilliam20a. Mathod of Disposition 20b. Placa of Disposition (Nama of comatary, cramatory or other placa) Data 20c. Location - City or Town, Stata 1 □ Burial 2 □ Cramation 3 □ Ramoval from Stata 4 □ Donation 5 □ Othar (Spacify) Parklawn 8-18-98 Wheaton, Md. 21. Signatura of Funaral Sarvice Licensee 22. Nama and Addrass of Facility Marshall's Funeral HOme, marchall 4217 9th. St. N.W. Wash. 25a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. 20011 Approximata Intarval Between Onsel and Death Physician MATASTATIL BREAKT CONCLA /Medical Immediata Causa (Final disaasa or condition resulting In daath) Examiner Dua to (or as a consequence of) Examiner The law requires that the death cartificate be axecuted Sequentially fist conditions, if any, laading to immadiata cause. Enter Undarlying Causa (Diseasa or Injury that initiated avants rasulting in deeth) Last and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, been signed by the attanding physician should be datached for usa as tha buria Physiclan/Medical Dua to (or as a consaguanca of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by Completed 24a. Was an autopsy performed? 24b. Wara autopsy findings available prior to completion of cause of death? this cartificata has 1□ Yas 2□ No 1 ☐ Yas 2 ☐ No spital or Attending Physician: Theoris after death.

neral Director: After this carificate y filled in by the funeral director, pe 25. Was case referred to medical examinar? Be 26. Placa of Death (Check only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatiant 3 ☐ DOA Othar: 4 ☐ Nursing Homa 5 ☑ Rasidance 6 ☐ Othar (Spacify) Certification: To 1 Yas 2 No 27. Menyer of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred 5 Pending invastigation 1 Naturel 1 Tes 2 No 2 Accidant 6 Could not be determined 3 Suicida 28a. Place of Injury - At homa, farm, streat, factory, office building, etc. (Spacify) 28f. Location (Straet end Number or Rural Routa Number, City or Town, State) 4 Homleida To the Hospital of within 24 hours af To the Funeral D complataly filled i 1 Cartifying Physician: To tha best of my knowledge, death occurred at tha time, dete and place, and due to the ceusa(s) and mannar as steted.

2 Madical Examinar: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and mannar stated. Medical 29a. Certifiar 29b. Signatura and title of certifier 29c. Licensa number 29d. Data signed (Month, Day, Year) D18320 10 30. Nama and address of person who completed causa of daath (Item 23e) (Type, Print) Johns Appicios DNWlogy CASTER BEHTHORZ MJ 21287. John FETTING-13 31. Data filad (Month, Day, Yaar) 32 Registrar's Signatura State AUG 1 8 1998 Registrar

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Data of Death 3. Tima of Death Month **Physician** 6:35 AM GIBSON NORMA AUGUST 18 1998 /Medical 4e. Facility Nama (If not institution, giva street and number) 4b, City, Town, or Location of Death 4c. County of Deeth Examiner MONTGOMERY GENERAL HOSPITAL OLNEY MONTGOMERY 7. Age (In yrs. last birthday) If Undar 1 Yaer If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Sacurity Number Birthplaca (Stata or Foreign Country) **Funeral** 1□M 2KIF Yrs. 246-44-3407 Director 64 FEB. 27, 1934 NORTH CAROLINA Usual Rasidance of Decedant 10a Stata r 28a-f show 10b County 10c. City, Town or Location 10d. Insida City Limits WASHINGTON, D.C. Director TY Yas 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 must be Items 23a 1224 ASPEN ST. N.W. 20012 UNITED STATES AMERICA Funeral 12. Was Dacedent Ever in U,S. Armed Forcast 1 ☐ Yas 21 Avo If Yas, GiveA Yeer or Datas: 14. Race - Amarican Indian, Black, Whita, atc. Was Dacedant of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) r than "natural", or lear the Medical Examiner 1 Nevar Marriad 2 Married 1 ☐ Yas ZXNo Specify: BLACK þ 3 ☐ Widowed 4 ☑ Divorced Completed 18a. Decedant's Usual Occupetion (Give kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decadant's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Eiementary/Secondary (0-12) Collega (1-4or 5+) NURSE 2YRS. PRIVATE permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If them 27 is marked other any injury or other traumatic event, I 17. Fethar's Nema (First, Middle, Last) 18. Mothar's Name (First, Middla, Maidan Surname) Be JAMES D. JONES JOHNNIE MAE HOWARD 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Straat and Number or Rural Route Number, City or Town, Stata, Zip Code) PATRICA GORDON (SISTER) 1224 ASPEN ST. N.W., W.D.C. 20012 20b. Place of Disposition (Nama of cematary, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Steta 1 ☐ Buriat 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATORY AUG. 24, 98 BELTSVILLE, MD. 21. Signatura of Funaral Sarvice Licensee 22. Nama and Addrass of Facility JOHNSON & JENKINS, INC. 716 KENNEDY ST. N.W., W.D. romplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, only one cause on each line. 716 KENNEDY ST. N.W., W.D.C. 23a. Part1. Entar tha diseese, or shock, or heart failura. List Approximate Intarval Batween Onset and Daath Physician Congestive Heart failure Immediete Ceuse (Final diseasa or condition rasulting in daath) Examiner Physician/Medical Examiner physician and s the burial-transit Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaase or Injury thet initiated evants rasulting in daath) Last Dua to (or es e consaquance of): Box 68760, Dua to (or as a consequance of): 88 P.O. 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown Diaheles Records. þ 24b. Were autopsy findings eveilabla prior to Completed 24e. Wes en eutopsy complation of cause of death? Tha law 1 Yas 25 No 1 ☐ Yas 2 ☐ No Division of Vital To the Hospital or Attending Physician: Be 25. Was casa rafarred to madical axaminar? 26. Placa of Daath (Check only ona) Hospital: 1 Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 X Yes 2 No Certification: To this by the funaral 27. Mannar of Death 28b. Tima of 28c. Injury at Work? 28d. Dascribe how Injury occurred 5 Panding invastigation 1 Natural 4 hours efter death. 1 ☐ Yas 2 ☐ No 2 Accidant 3 ☐ Suicida 6 Could not ba 28a. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 | Homicide within 24 hours of To the Funeral I Tertifying Physician: To tha best of my knowledga, daath occurred et tha tima, data end place, end dua to tha causa(s) and menner es steted.

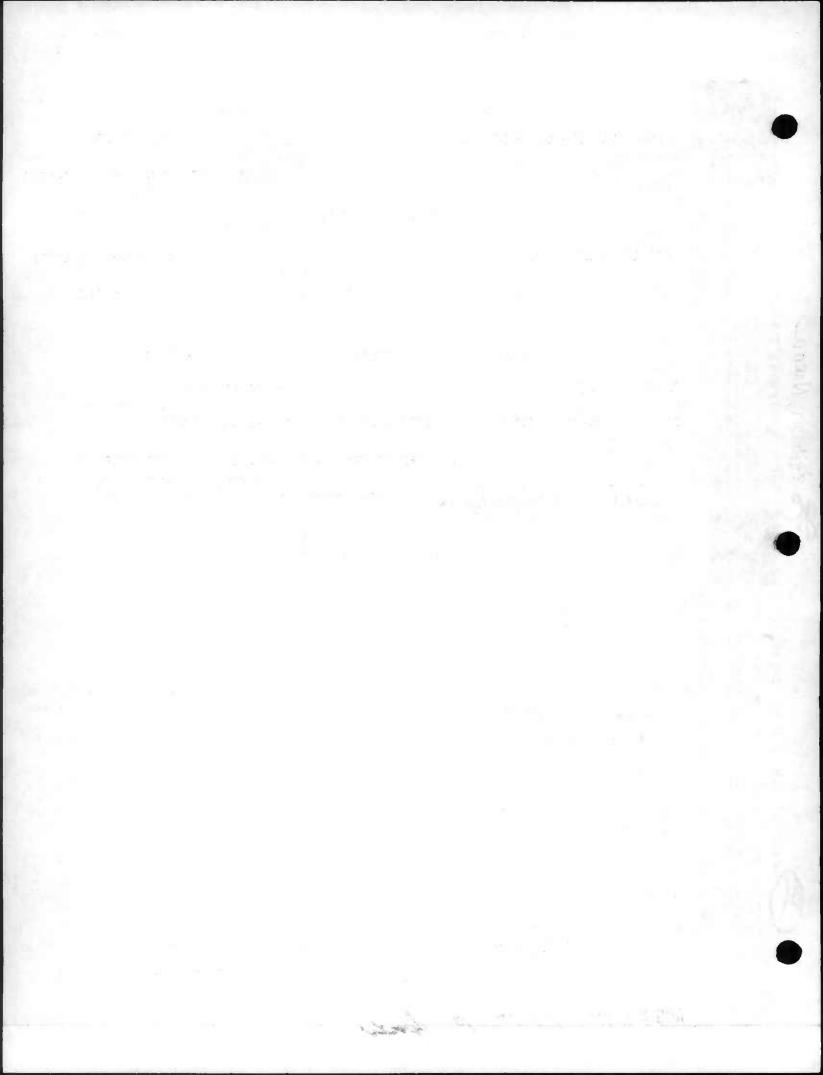
| Medical Examinar: On tha basis of examination and/or invastigation, in my opinion, daath occurred et the time, date and place, and dua to tha cause(s) end mannar stated. 29a. Cartifier Medical (Check only one) 29b. Signatura and titla of certifiar 29c. Licansa numbar 29d. Data signed (Month, Dey, Year) AVGUST 19 1998 D37891 Congression at Ln # 409 Rockville MP 20852 30. Nama and address of person who complated causa of death (Item 23a) (Type, Print) A RAJVANSHI MD 121 31. Dete filad (Month, Day, Yaar) 32. Ragistrar's Signetura

State Registrar

AUG 2 0 1998

32. Ragistrar's Signetura

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(3)		30. Neme and address of person who	completed cause of death /	1, 11	Print)	0010		August	14, 1998
(2)		DR. C. SCHE				CKVILLE,	MD. 20	0850	
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Registr	ar	AUG 1 8 1998	The same of the sa	10.	pach	5			

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day GARNER LORRAINE ANGELUS 23, AUGUST 1998 3:00 PM 4a Facility Name (If not institution, give street and number) 4h. City: Town, or Location of Death 4c. Qounty of Death 9. Birthplaca (State or Foreign Country) . Age (In yrs. last birthday) 1□ M 2♥ F 76 579-22-2471 Washington, DC 8,1921 Sept Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits CHARLES WALDORF 1 TYes 2 N No MARYLAND 10e Street and Number 10f Zip Code 10n, Citizen of What Country? 12835 WALDORF FOREST ROAD 20601 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 💢 No 1 Never Married 2 X Married 1 Yes 2 No Specify: Specify: WHITE 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HECHT COMPANY SALES CLERK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) LOUISE BEYMER BERNARD EDWARDS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12835 WALDORF FOREST RD, WALDORF, MARYLAND 20601 LORRAINE A. BAUCKMAN/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation, 5 Other (Specify) 5' Other (Specify) MARYLAND VETERANS' CEM. AUG 27,1998 CHELTENHAM, MD 21. Signature of Tunera Service License 22. Name and Address of Facilit THE HUNTT FUNERAL HOME, INC. 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dauge on each line. 20604 Approximate Intervel Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ENFARCEON ARUTE MUDEARDIAC Due to (or as e consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy

Physician /Medical Examiner

certificate be executed

68760

Box

P.O.

Records.

of Vital

Division

Physician

/Medical

Examiner

10a. State

Funeral

Director

rai", or items 23s or 28s-f show Examiner must be notified at

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permit. Peges 1 and 2 should be file Department of Health end Mental Hy Important: If flem 27 Is marked othe any Injury or other traumatic avent, place.

Baltimore, Maryland 21215-0020

Physician/Medical Examiner ician and burial-trans physician the burial USB for þ Be Completed page Medicai Certification: To To the Hospital or Attending Pt within 24 hours after deeth.

To the Funeral Director: After the completely filled in by the funeral

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25. Was case referred to medical 1 Yes

29a. Certifier

2 No 27. Menner of D 1 Natural er of Death 2 Accident

3 ☐ Suicide 4 Thomicide

(Check only one)

29b. Signature and title of certifier

5 Pending investigation 6 Could not be

Hospital: 1 1 inpatient

2 ER/Outpatient

28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify)

1 Yes 2 No

3 DOA

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury et Work?

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Yes 2 No

1 ☐ Yes 2 ☐ No

1 Certifying Phyelcian: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month. Dav. Year)

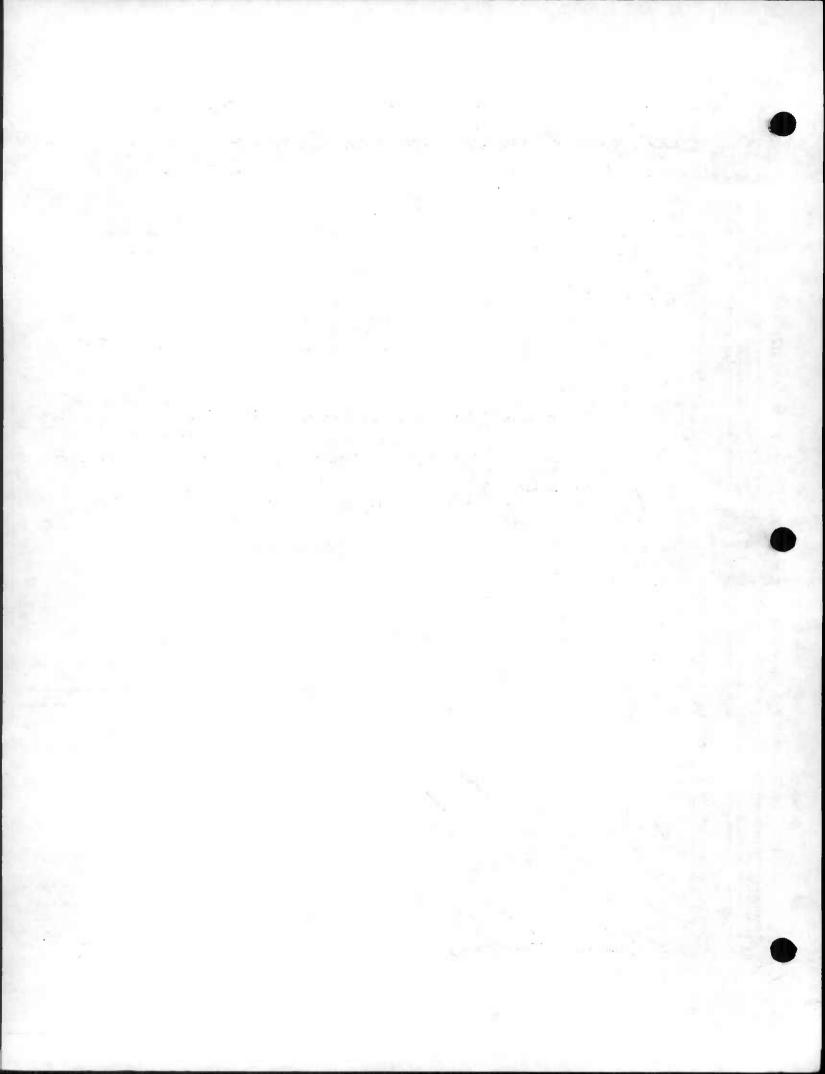
/cent 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

> Jr., 7503 Surratts Rd., Clinton, MD 20735 kenneth T. Larsen,

State Registrar 31. Date filed (Month, Day, Year) AUG 25 1998 32. Registrar's Signature

29c. License number

D30135



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State of Maryland / Department of Health and Mental Hygiene®

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Physician	
/Medical	
Examiner	

Funeral

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Baltimore, Maryland 21215-0020

Physician /Medical Examiner

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1. Decedant's Name (First, Middle, Last) 2. Data of Daath 3. Time of Death Month Stephen Michael Greathouse 18, AUGUST 1998 0850AM 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth CHARLES COUNTY HUGHSVILLE 15100 BURNT STONE ROAD 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sax 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) Days Months Hours 1 MM 2□ F 217-68-6297 41 Yrs. Indiana October 24, 1956 Usuel Residence of Dacedent 10a State 10b. County 10c. City, Town or Location 10d. inside City Limits 1 ☐ Yas 2 ■ No Charles Maryland Hughesville 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 15100 Burnt Store Road 20637 United States 12. Was Decedant Ever in U,S. Armed Forcas? Wes Decadant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuben, Maxican, Puarto Ricen, atc.) 14 Bace - American Indien Black, Whita, atc. 1 ☐ Yas 2 ■ No If Yes, Giva Yaar or Datas: 1 ☐ Nevar Married 2 Married 1 ☐ Yas 2 ■ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedant's Education (Specify only highast grede completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Collaga (1-4or 5+) Elementary/Secondary (0-12) Counselor State Health Department 18. Mothar's Name (First, Middle, Maiden Sumama) 17. Fether's Nama (First, Middle, Last) Be Okey James Greathouse Ellen Jane Hammond 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) Karoline M. Greathouse, Wife 15100 Burnt Store Road, Hughesville, MD 20637 20b. Place of Disposition (Nama of camatary, cramatory or other place) Data 20c. Locetion - City or Town, Stete 20a. Method of Disposition 1 ■ Burial 2 Cremation 3 Removal from Stata Charles Memorial Gardens 8-22-98 Leonardtown, Maryland 4 □ Donation 5 □ Othar (Specify) 21. Signature et Foheral Service L 22. Nama and Addrass of Fecility 0 Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650 Ronald L. Thompson, Jr. M01154 23a. Part1. Entar tha disaasa, or complications that ceusad tha death. Do not antar tha mode of dying, such es cerdiac or respiratory errest, shock, or heer failure. List only one ceuse on each line. Approximeta Intarval Between Onsat and Daeth Immediata Causa (Final disaese or condition rasulting in death) . Hypertensive Arteriosclerotic Cardiovascular Disease Due to (or es e consequence of): Examiner Sequantially list conditions, if any, laading to immediata ceusa. Enter Underlying Causa (Disaasa or Injury Dua to (or as a consequence of): Physician/Medical that initiated avants rasulting in daath) Last Due to (or es e consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 € Unknown Hepatitis C by 24b. Were eutopsy findings aveilabla prior to complation of ceusa of death? Completed 24a. Wes an eutopsy performed? INSPECTION 1 Tyas 2 No 1 □ Yas 2 □ No 25. Was cesa referred to medical examiner? Be 26. Placa of Daath (Check only one) Othar: 4 ☐ Nursing Homa 5X Rasidance 6 ☐ Othar (Specify) Lo 1⊠ Yas 2□ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mennar of Deeth 28a. Deta of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how Injury occurred 28c. Injury at Work? Certification: 1 XNaturel 5 ☐ Panding 1 ☐ Yas 2 ☐ No invastigation 2 Accident 6 Could not be datarmined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straet, factory, office building, atc. (Spacify) 4 Homicida 29a. Cartifiar 1 Certifying Physician: To tha bast of my knowladga, daath occurrad at tha tima, data and place, and dua to the causa(s) end menner as steted. edicai 2 Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. (Check only one) 29b. Signatura and titla of cartifian 29c. Licansa number 29d. Data signed (Month, Day, Year)

State Registra

31. Data filed (Month, Day, Year) AUG 2 1

Joseph Pestaner,

32. Registrer's Signetura

laner, M.D

30. Nama and addrass of person who complated ceuse of deeth (Item 23a) (Type, Print)

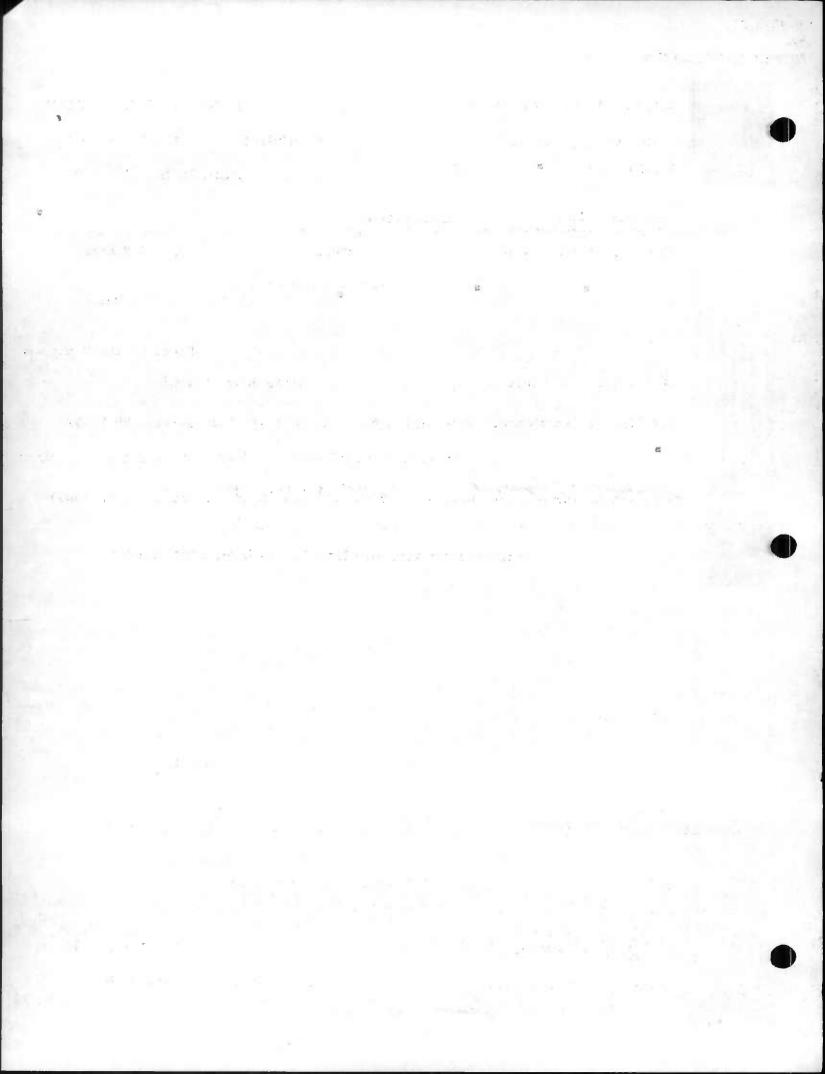
M.D.

Annika)

O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

AUGUST 18, 1998



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ate of Maryland / Department of Health and Mer	ntal Hygiene 8 2/02	
Certificate of Death	One No	

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Physician	ı
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1. Decedent'a Name (First, Middle, Last) PAUL

ANTHONIO

2. Dete of Deeth AUG. 15, 1998

3. Time of Death 0:655am

N Yes 2 No

Funeral Director

Director

Funeral

by

Completed

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Examiner

Physician/Medical

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Certification:

Medical

the Maryland Pages 1 and 2 should be filed within 72 hours after death with the Maryle nant of Health end Mental Hygiena.
Int: If flear 27 is marked other than "nature", or flems 23a or 28a-f show int; if flems 0.2 is marked other than "nature", or other traumatic event, in Medical Examine must be notified as iny or other traumatic event, in Medical Examine must be notified.

/Medical

permit. Pages Depertment of Important: If it any injury or o **Physician** Examiner physician and the burial-transit that the daath certificate be executed Box 68760. 98 Division of Vital Records, P.O. signed by the s need should irector, page 2 s aftar daath.

Director: After this certifications director, funeral by the f To the Hospital or A within 24 hours aftar To the Funeral Directompletaly filled in by

GILLETT 4a Fecility Name (If not institution, give street and number) SHADY GROVE ADVENTIST HOSPITAL ROBERT SHADY 4b. City, Town, or Location of Death 4c. County of Death ROCKVILLE MONTGOMERY

If Under 24 Hrs. 8. Date of Birth
Hours Min. FEB. 24, 1959 JAMAICA 267-37-4895 Usuel Residence of Decedent 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits MD. FREDERICK FREDERICK 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 614 HUNTING RIDGE DRIVE 21703 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Raca - American Indian. Armed Forces?

1 Xes 2 No If Yes, Give Yeer or Dates: Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) INSURANCE COMP. College (1-4or 5+) 4 YRS. Elementary/Secondery (0-12) SALES 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) STANLEY GILLETT RUBY BARRETT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informant's Name/Relationship (Type, Print) SANDRA V. GILLETT (WIFE) 614 HUNTING RIDGE DRIVE FRED. MD. 21703 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removel from State RESTHAVEN MEM. GARDENS AUG. 22,1998 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility olleus GARY L. ROLLINS FUNERAL HOME 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, Interval Between Onset end Death Immediate Cause (Final disease or condition resulting in death) THROMBUS 1 DAY GROW ARY SINUS Due to (or es e consequence of): 4ER CRISIS SICKLE IDAY ACUTE Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that infliated events resulting in death) Last Due to (or es a consequence of): BGTA THALGSOMMA 39 46848 Due to (or es e consequenca of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part i. GLOMBERS SCHOLOSIS FOCAL 24a. Was en eutopsy

23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown

> 24b. Were eutopsy findings available prior to completion of cause of death?

12 Yes 2□ No

1 Yes 2 No

25. Was case referred to medical examiner? 1☐Yes 2☐ No

28a. Dete of Injury (Month, Dey Year) 5 Pending Investigation

28b. Time of

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 Yes 2 No

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred

26. Place of Death (Check only one)

29a. Certifier (Check only one)

27. Manner of Deeth

1-UNeturel

2 Accident

3 Suicide

1th Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and piece, end due to the ceuse(s) and manner as atated.

2 Medical Examiner: On the besis of exemination end/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the ceuse(s) end manner stated.

29b. Signeture end title of certifier

29c. License number

29d. Date signed (Month, Dey, Year)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

6 Could not be determined

M.D.

MARYLAND D42452

AUGUST FOFTENTH, 1998

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) DR. CHITRA RAJAGOPAZ, M.D. PHILIP 18/11, PRINCE DRIVE SUITE 327, OLNEY 20632

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 27022

		1. Decedant's Nama	(First, Middla, La	st)		0011	ificate of	Douti	2. Data of Deat	ng. No.	3	3. Time of Death
Physician /Medical									Month	Day	Yaar	
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To the Fune completely fi	M	30. Name entlandras		completed cause of M. D			int)		rick. MD	8/19 21701	198	

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Year **Physician** CHARLES FRANCTS HILL August 11, 1998 9:04 PM /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth **Examiner** Wicomico PO Box 686, Bethel Road Willards 7. Age (In yrs. lest birthday) If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) 18/17/1922 5. Social Security Number g. Birthplece (Stete or Foreign Country)
Washington D.C. 6. Sex 1 M 2 ☐ F **Funeral** Director 228-12-1884 Usual Residence of Deceden 10e. Stete 10b. Counts 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28a-f show traumetic event, the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Somerset Manokin 10g. Citizen of Whet Country? 10e. Street end Numbe 10f. Zip Code PO Box 63 21836 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 □ No If Yes, Give Year or Dates: WWT.I 14. Race - American Indien, Bleck, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: à 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If item 27 is marked other than? Elementary/Secondery (0-12) College (1-4or 5+) Refrigeration Auto Body 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Charles E. Hill Alice Pauline Kussmaul 0 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 a Department of Health as Important: If item 27 is any injury or other trau once. PO Box 63, Manokin, Md. 21836 Marie Elizabeth Hill/Wife 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Md. Veterans Cemetery 8/14/98 Hurlock, Maryland 21. Signeture of Funeral Service Lice 22. Neme end Address of Fecility Hinman Funeral Home M00295 11673 Somerset Ave., Princess shock, or heart feilure. List only one ceuse on eech line. Princess Anne, Md. 21853 Approximete Intervel Between Onset end Deeth Physician several days /Medica! Immediate Cause (Final disease or condition resulting in death) Porlumma Examiner Due to (or es e consequence of): Examiner physician end s the burial-trensit certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequenca of): P.O. Box 68760. Physician/Medical Due to (or es e consequence of) 28 ettending use jo Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. signed by the d 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown dementia - Alzheimer's type Division of Vital Records. þ multiple decubiti 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? peen 1 Yes 2 No 1 ☐ Yes 2 ☐ No this certific Be 25. Wes case referred to medical examiner? 26. Piece of Deeth (Check only one) Hospital: 1 | Inpetient 2 | ER/Outpetient 3 | DOA Other: 4 Nursing Home Aesidence 6 Other (Specify) 2 1 Yes 2 No funeral 27. Manner of Deeth 28e. Dete of Injury (Month, Day Yeer) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury et Work? Attending After 1 Neture 5 Pending death. 1 Yes 2 No 2 Accident investigation or Attend efter death Diractor: / filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours eff To the Funeral DI completely filled in Certifying Phyelcian: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steled.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end pleca, end due to the cause(s) end menner stated. 29e. Certifier Medicai (Check only one) 29b. Signeture end title of terriller 29c. License number 29d. Date signed (Month, Dey, Year) D30853

State Registrar

harles

32. Registrar's Signeture 31. Date filed (Month, Dey, Year) AUG 1 4 1998

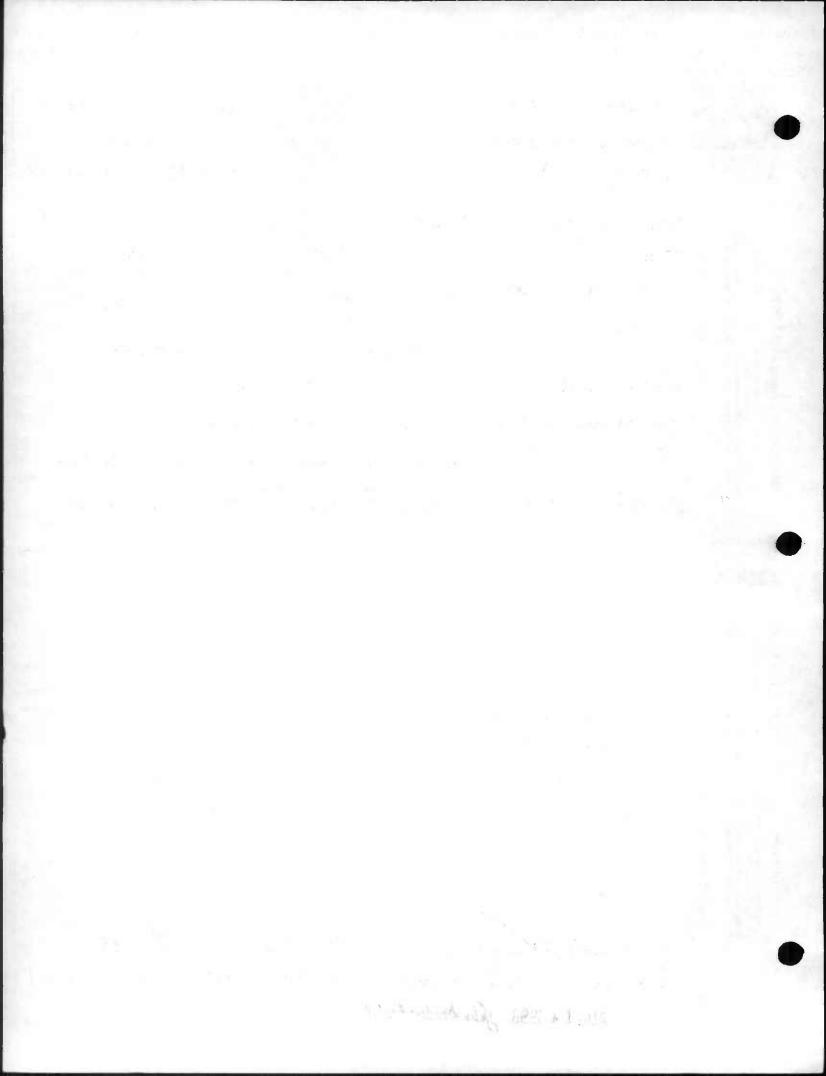
Jr MD

100 Power Street Salisbury mo 2180 1

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

Silvia

3.

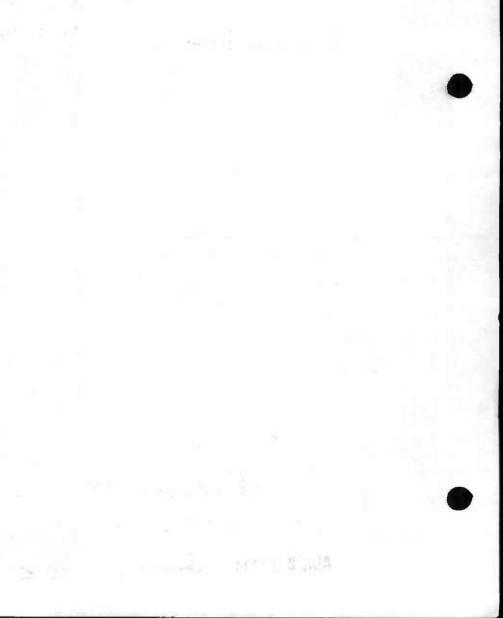


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State of Maryland / Department of Health and Mental Hygiene 2 7 0 2 4

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Physician /Medical			ako Sue I	J					Month	Day	10	Yeer	
		4a. Facility Name (If not institution	У			4b. City, Town, o	Augu			998 of Death	4:00 p.		
Examir	ier	Sunrise Ca	A CONTRACTOR OF THE PARTY OF TH							eetii 4C.		Cecil	
		5. Social Security Number	6. Sex		s. lest birthday)	If Under	r 1 Year	E1k		Birth			nce (State or Fore
ineral ector		215-52-3919 Usuel Rasidanca of Decedent	1□M XXF	73	Yrs.	Months	Days	Hours Mi	Nov.	Birth Day, Year) 4,192	24	Count	ace (State or Fore ry) apan
10		10a. State 10b. County		10c. C	ity, Town or Loc	cation						10	d. Insida City Limi
He de tor	to	Maryland	Cecil				Char	lestown					1 X Yas 2 □ f
r 28a		10e. Street and Number				10f. Zip	p Coda			10g. Citi	izen of V	Vhat Counti	ry?
Q.	a D	707 Caroline S	treet				2	1914			U.S	.A.	
triban "netural", or itema 23a or 28a-f ehow the Medical Examiner must be notified at ompleted by Funeral Director	by Funer	11. Marital Status 1 □ Nevar Merried 2 □ Marrie 3 ☒ Widowed 4 □ Divorced	Armed F	2 X No				dispanto Origin? en, Maxican, Pue Specify:	Specify Yas of orto Rican, etc.	No-		e - Amarica k, Whita, a	
	ed	15. Decedant	's Education		16a. Deceda	ant's Usu	al Occup	pation	andrina.	16b. K	Ind of Bu	ısınass/indu	stry
	Completed	(Specify only highes Elemantary/Secondary (0-12)		1-4or 5+)	lifa. D	OO NOT u	ork dona ise ratire	pation during most of w d)	orking				
	TO.	Twelve Years			H	omem	aker			Pe	erson	nal R	esidence
event,	Be (17. Father's Name (First, Middla, L	.ast)					18. Mothar's N	ama (First, Mic	dla, Maidan	Sumam	a)	
traumatic event, it	2	Kin	Nee ShiBa	ata				Dei	ntaro (maider	n nai	me un	known)
-		19a. Informant's Name/Ralationsh	llp (Type, Print)		19b. Malling	g Addras	s (Street	and Number or i	Ru <i>ral Rou</i> ta Nu	mber, City o	or Town,	Stata, Zip (Coda)
		Eleanor Munro (sister-i					, Clark	sville,	New	York	k 120	041
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Important: If item any injury or othe once.		4 Donation 5 Other (Sp			A. Ferr	is &	Com	pany	8199	3 West	Ches	ter, Pe	ennsylvani
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DHMH 16 Rav 6/95



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State of Maryland / Department of Health and Mental Hygiene

	Funera Directo
Baltimore, Maryland 21215-0020	permit. Pagas 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health and Mentel Hygiene. Important: If item 27 is marked other then "natural", or items 23s or 28e-f show sny injury or other traumatic event, the Medical Exemples in an item 25 once.
	Physician /Medical Examiner

RICHARD H	Decedent's Name (First, Middle, L.)	act	Ce	rtificate	טו טפו	aut	2. Dete of Dee	leg. No.		3. Time of Deeth
Physicia /Medic	an Richard Espeth F		Sr.				Month	15, 199	98 ^{Yeer}	5:30 PM
Examin	to Conttle . Nome /// not in stitution of					ity, Town, or l RENTWO	ocation of Deeth		y of Deeth NCE GI	EORGES
Funeral Director	5. Social Security Number 6. 577-42-5172	Sex XXM 2□ F	ge (In yrs. last birthday) 66 Yrs.	If Under 1 Y Months D		Under 24 Hrs. ours Min.	8. Dete of Birth (Month, Dey Jan. 2	, Year)		elece (Stete or Foreign etry) ington, D
	Usuel Residence of Decedent 10e. Stete 10b. County		10c. City, Town or Lo	ocation						0d. Inside City Limits
tha Merylar 28a-f show	. 100	George's	Brentwo	od						1 X Yes 2□ No
3a or 2	10e. Street and Number 3402 40th Place			10f. Zip Co			1	10g. Citizen of USA		Ary?
5-0020 72 hours after death with the Meryland naturel; or ferms 23e or 28e-f show acel Exercited in the beneated to a contribution.	Prince 10e. Street and Number 3402 40th Place 11. Marital Status 1 Never Married XX Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces?	Ever in U,S. 13. No 1/54-12/55	1 Vac 27		ntc Origin? (S) lexicen, Puerto pecify:	pecify Yes or No- o Ricen, etc.)	Ble	ce - Americ eck, White, fy:Blac	etc.
21215-0020 d within 72 hours af giene. r then "netural", or the Medical Exerci-	15. Decedent's E (Specify only highest g.	ducetion rade completed)	16a. Dece (Give life.	dent's Usuel O kind of work of DO NOT use r	done durin retired)	g most of wor	king	16b. Kind of B	Business/Inc	dustry
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rland bid be fil fentel H ked out	17. Fether's Neme (First, Middle, Les David Hickerson					Jena Ne	ne <i>(First, Middl</i> a, 1son	Maidan Sume	me)	
Maryland d 2 should be file th and Mentel Hy 77 is marked othe treumetic svent	19e. Informent's Neme/Reletionship John Hickerson	(Type, Print)					rel Route Numbe			
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Physician /Medical Examiner	23a. Part1. Enter the diseese or conshock, or heert failure. List only Immediate Ceuse (Finel diseese or condition rasulting in daath)	mplications that cause on each i		ter the mode o	of dying, su	uch es cerdied			Pike	, FV., MD Approximate intervel Between Onset end Deeth
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or Attending or Attending after death. Sirector: Afte in by the fun	Natural 5 Panding investigeti 3 Suicide 4 Homicide Gatemine	be 28a. Place of In	jury - At homa, farm, st ic. (Specify)	М	1 🗆 Yes	2 🗆 No	28f. Location (S City or Tow	Street end Nun n, Stata)	ber or Rure	al Route Number,
Division tel or Attending rs after death. al Director: Afte	27. Manner of Death Natural 2	28a. Place of In building, et	jury - At homa, farm, st c. (Specify) of my knowledge, deet of exemination and/or in	M raat, factory, of	ffice	ata end place	28f. Location (S City or Tow	Street end Nun n, Stata) ceuse(s) end n	nber or Rure	stated.

Registrar

31. Dete filed (Month, Dey, Yaer) AUG 2 1 1998

end eddress of person who complated ceuse of death (Item 23e) (Type, Print)

O.C.M.E

111 Penn Street, Baltimore, Maryland 21201

AUG. 16, 1998

metini er

Testi sour

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. 7 State of Maryland / Department of Health and Mental Hygiene

	Decedant's Nama (First, Middla, L.	ast)	Certifica	te of Death	2. Data of Dea	th	3. Time of Death
ysician	- 1	. 1//			Month 08	Day Yas	
Medical aminer	Fannie Lee: 4a Facility Nama (If not institution, g		,	4b. City, Town, or	Location of Daath	4c. County of D	
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rector	10a. State 10b. County	Georges H	City, Town or Location	7.			10d. Inside City Limits 1 Yas 2 □ No
ciner count be notified Funeral Director	10e. Street and Number	01/2	101. 2	lip Code		10g. Citizan of What	Country?
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Com	12		Houseu			NIA	
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	Milton Allen			Unkr			
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o det		1000				2010	Frobably 4 Olikilowii
pege 2 should be deteched for use.					24a. Was perfo	an autopsy 24	b. Were autopsy findings available prior to completion of cause
Pege 2						V	of daath?
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Baltimore, Maryland 21215-0020 YUGA. HOWARD HEISS

Physician

/Medical

Director

Funeral

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Completed

Examiner

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it a Modical Examiner must be notified at

d 2 should be filed within 7 th end Mental Hygiene.
7 Is marked other than "r

Department of Health er Important: if Item 27 is any injury or other trau

Physician /Medical

the Meryland

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Tima of Death 1998 AUG 5:35 A:M HUGH HOWARD HEISS Sr 4e. Fecility Name (If not institution, giva straet and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth CHARLES LAPLATA CIVISTA MEDICAL CENTER 5. Social Sacurity Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. lest birthday) Birthpleca (Stata or Foraign Country) 15 M 2□ F Deys Yrs 58 578-52-8655 July 16 1940 Washington, DC Usuel Residence of Deceden 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Charles White Plains 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20695 USA PO Box 236 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, atc. 11. Maritel Status 1 Never Merried 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Yaar or Dates: 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Truck Driver Delivery 17. Fether's Nema (First, Middle, Last) 18. Mother's Nama (First, Middla, Meiden Sumema) Anna Erbb Heiss Keil Heiss 19e. Intorment's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 4702-B Rookewood Place Waldorf, MD 20602 Virginia L. Diehl (daughter) 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burlel 2 Crametion 3 Removal from State Trinity Memorial Gardens 8-25-98 Waldorf, Maryland 4 ☐ Donelilon 5 ☐ Other (Specify) 21. Signeture of Funara Service/Licensea 22. Name and Address of Fecility M00173 J.H. Eberwein Mortuary 4433 White Pls La White Pls, MD 20695 her the disease, or complications thet caused the deeth. Do not anter the mode of dying, such as cardiac or raspiratory arrest, heart teilure. List only one ceuse on each line. Approximete Intervel Between Onset end Deeth Immediete Ceuse (Finel diseese or condition resulting in deeth) Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in death) Lest Dua to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? Probably 4 Unknown 1 Yes 2 No 24b. Were eutopsy tindings aveileble prior to completion of cause ot deeth? 24e. Wes en eutopsy performed? 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Hospitel: Inpatiant 2 ER/Outpetient 3 DOA DANO Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? 5 Pending 1 TYes 2 □ No Investigation

Examiner physician end s the buriel-trens Box 68760 980 P.O. signed by the e Records, pege 2 has certificate Division of Vital al or Attending Physician: The setter death.

In Director: After this certificated in by the funeral director, per in 24 hours effe the Funeral Dir npletely filled Ir

Examiner Physician/Medical þ Completed Be Certification: To

Medical

1 ☐ Yes

(Check only

Menner of Deet Naturel 3 Suicida

6 Could not be determined 4 Homicide 29a. Certifier

28e. Piece of Injury - At home, tarm, street, factory, office building, etc. (Specify)

28t. Location (Street end Number or Rural Routa Number, City or Town, Stete) Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the cause(s) and menner es stated.

Madicat Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner stated.

29b. Signature and title of certifier

29c. License number D-20629

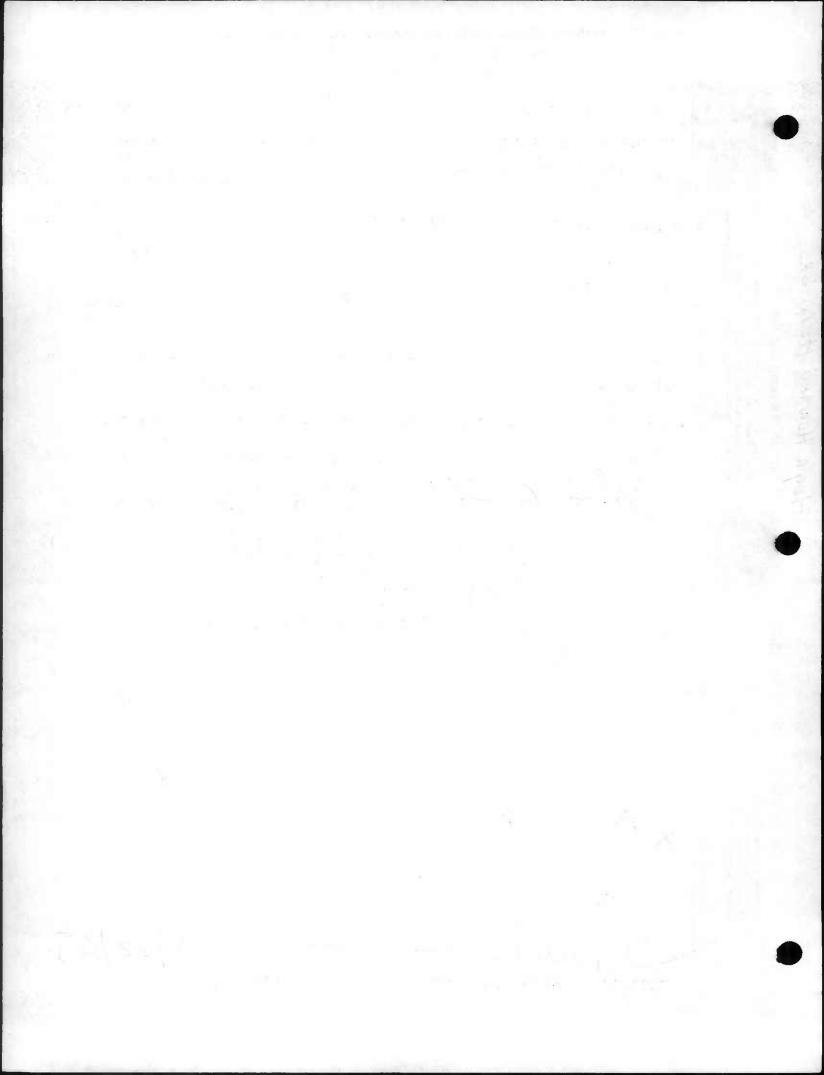
29d. Date signed (Month, Dey, Year)

30. Name and address o person who completed cause of deeth (Item 23e) (Type, Print)

GEORGE WITHEN MD 11345 PEMBROOKE SQ. SUITE 103 WALDORF, MD. 20603

State Registrar 31. Data tiled (Month, Dey, Year) AUG 25 32. Ragietrer's Signature

To the I within 2 To the I complet



98-4395-037

MICHAEL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible

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State of Maryland / Department of Health and Me	ntal Hygiene
Certificate of Death	Reg. No.

7028

HAYDEN
Physician /Medical Examiner

Funeral Director

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Manyland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic avent, the Medical Example must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the tunnel director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

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111 Penn Street, Baltimore, Maryland 21201

State Registrar

Stephen S. Re 31. Dete filed (Month, Dey, Yeer) AUG 04 1998

32 Registrer's Signature

Jako Skurlen-Rawlall

DHMH 16 Rev 6/95

- 13

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State of Maryland / Department of Health and Mental Hygiene

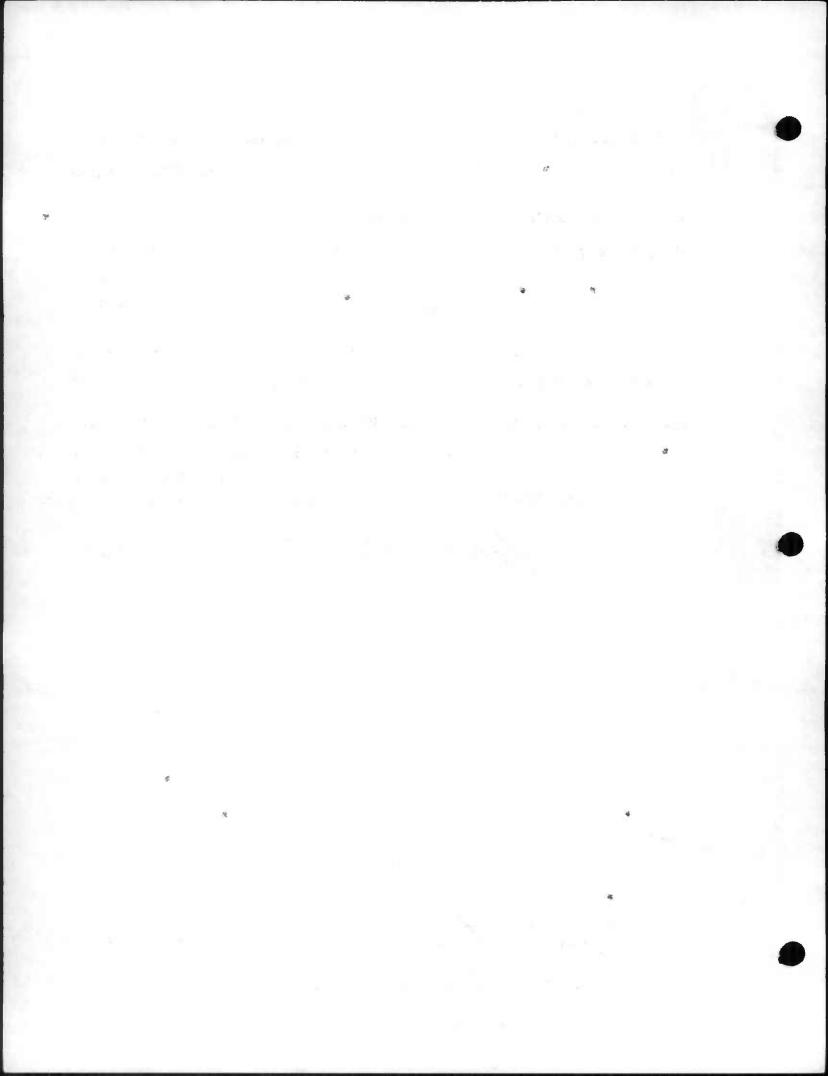
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Dey 1998 Month **Physician** August 5, Howard Elton Hagen 3:00 am /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** 45085 Millstone Lane Hollywood St. Mary's Months Deys Hours Min. July 14, 1919 5. Sociel Security Number 7. Age (In yrs. lest birthday) 9. Birthplece (State or Foreign **Funeral** 1 M 2 □ F 226-22-0856 79 Virginia Yrs. Director Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages I and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hydiena. Important If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Example must be notified at once. Maryland St. Mary's 1 □ Yes 2 ■ No Director Hollywood 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 45085 Millstone Lane 20636 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Married 2 Married 1 ■ Yes 2 □ No If Yes, Give Yeer or Detes: 1936–1941 Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ■ No Specify: Specify: White by 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collaga (1-4or 5+) Administrator US Navy/Defense 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middla, Maiden Sumame) Be Howard Elton Robinson Hazel Lucy Newman 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stata, Zip Coda) Katherine A. Hagen, Wife 45085 Millstone Lane, Hollywood, Maryland 20636 20a. Method of Disposition 20b. Place of Disposition (Neme of 20c. Location - City or Town, State Charles Memorial Gardens 8-08-98 Leonardtown, Maryland 1 ■ Burial 2 □ Cremation 3 □ Removel from State 4 Donetion 5 Other (Section) 21. Signatur Auneral Service Lice 22. Name and Address of Facility Brinsfield Fig. 22955 Hollywood Rd., Leonard:
23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart fellure. List only one cause on each line. 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Rd., Leonardtown, MD 20650-0279 Approximete
Intervel Batween Onset end Death Physician Immediate Ceuse (Finet disease or condition rasulting In death) /Medical Examine Examin The law requires that the daath certificata be executed burial-transit Sequentially list conditions, if eny, leeding to immediate causa. Enter Undarfying Causa (Diseesa or Injury that Initiated events resulting in deeth) Lest and Due to (or as a consaguance of) Box 68760. attending physician for usa as the buria Physician/Medicai Due to (or es e consequence of) P.O. I Pert II. Other eignificant conditions contributing to death but not resulting in the underlying causa given in Pert I. 23b. Did tobacco use contribute to the cause of death? 2 1 Yes 2 Die 3 Probably 4 Unknown been signed t Records, by 24b. Ware autopsy findings eveileble prior to completion of ceuse of deeth? 24a. Wes en eutopsy performed? Completed has e 2 page certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica complately filled in by the funeral director, Be 25. Was case referred to madical 26. Place of Death (Check only ona) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ■ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ■ No Certification: To 28e. Data of Injury (Month, Day Year) 27. Mennar of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Aratural 5 Panding 1 Yes 2 No invastigation 2 Accident 6 Could not be determined 3 ☐ Suicida 28a. Plece of Injury - At homa, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicida 1. Cartifying Phyeicien: To the best of my knowledge, death occurred at the time, date end piece, end due to the causa(s) and manner as steted.

2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end piece, end due to the causa(s) end menner steted. 29a. Cartifier Medical 29b. Signeture end till The 29c. License number 29d. Data signed (Month, Day, Year) D25230 6 August 1998 30. Name end eddrass of person who completed ceuse of death (Item 23e) (Type, Print) David C. Allen, M.D., P.O. Box 606, Leonardtown, Maryland 20650-0606 31. Date filed (Month, Day, Year) 32. Registrer's Signeture State Jalia Daviden Rardall Registrar

DHMH 16 Rev 6/95

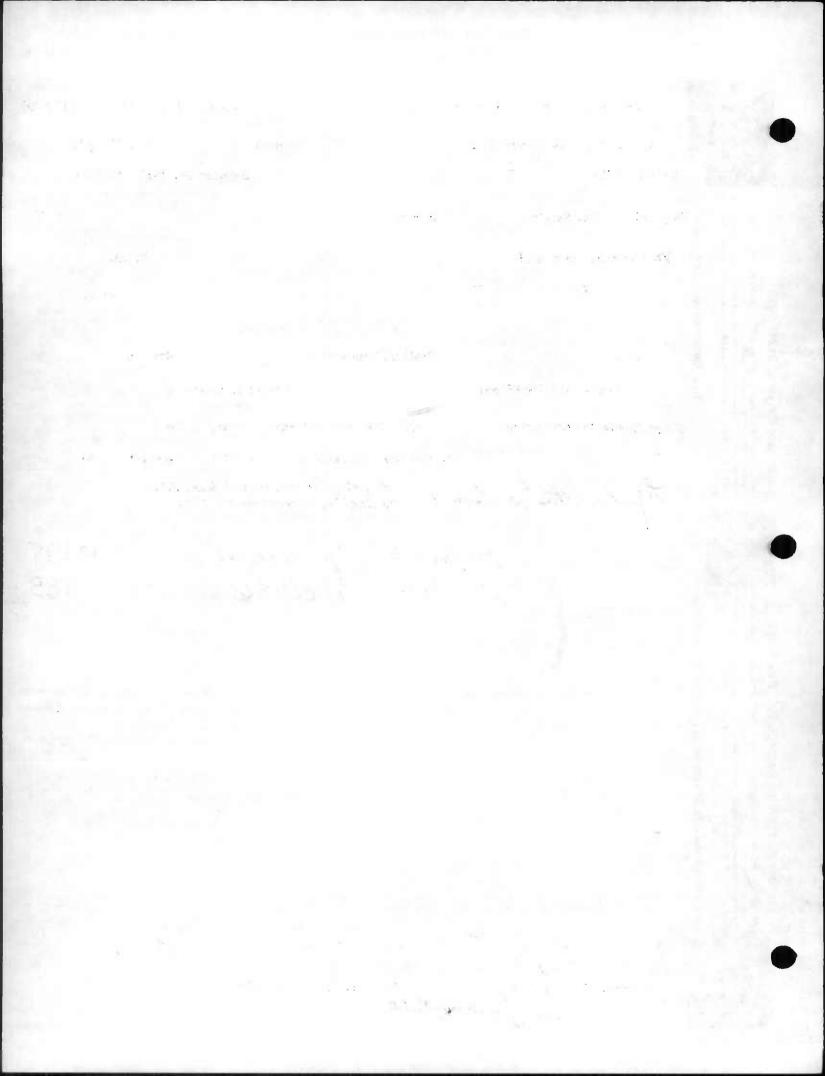
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	12 sh h end r is m traum		19a. Informant's Na											r, City or Town,	Stata, Zip C	oda)	
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	dentificata certificata rector, pag	Bec	25. Was casa rafar	red to madical							26. Place	of Death	(Check only o	ne)			
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5	s after de il Directo od in by th	Certification:	3 ☐ Suicida 4 ☐ Homicide	6 Could not b datermined	200. Fla	28e. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify)				2	28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)						
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Registrar

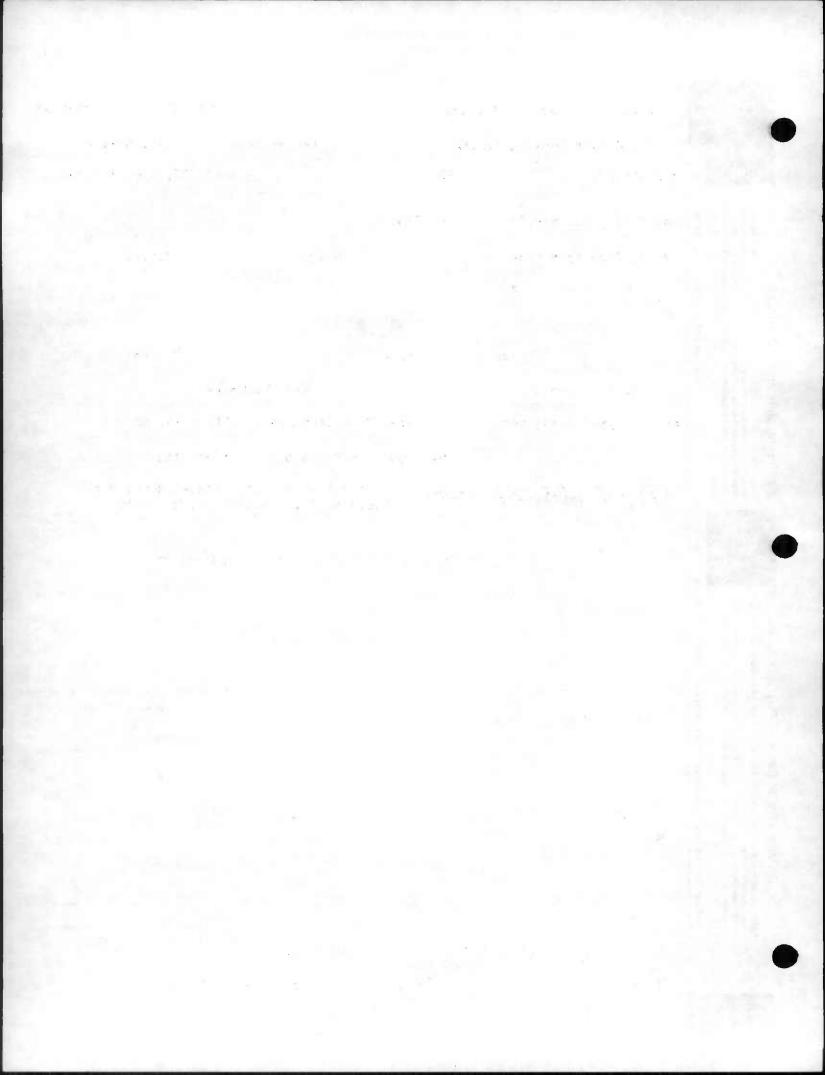


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State of Maryland / Department of Health and Mental Hygiene 27031

				Otato of W	arylana /			Death		Reg. No.	10.0	
	-	1. Decedent's Neme							2. Dete of De Month	Dete of Deeth Month Dey Yeer		3. Time of Death
	Physician /Medical	Paul	Herbe	rt Havw	ard				Augus			9:30 AM
	Examiner	4a Facility Neme (II		e street end number)				4b. City, Town, or	Location of Deet	4c. County	of Death	
4		St. Mary's Nursing Center Leonard 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) If Under 1 Year It Under 24 Hr.							town	own St. Mary's		
	Funeral	5. Sociel Security N	umber 6. S	Sex 7. Ag	e (In yrs. lest bi	Mo	Under 1 Year	r If Under 24 Hrs	8. Dete of Bir	th y, Year)		ce (Stete or Foreign
1	Director	579-42-3003 98 Yrs. A								27, 190		
	pue *	Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location									100	d. Inside City Limits
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0	ed within 72 hours ygiene. her then "neturel", ft, the Medical Exi Completed by	10	15. Decedent's E	ducetion	icetion 16e. Dece			pation	delina	16b. Kind of Bi	usiness/Indu	stry
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21	d will			4 yrs			Appraiser				state	
pu	should be filed very marked other to umatic event, in To Be Co.	17. Fether's Neme	(First, Middle, Last)				18. Mother's Ne	me (First, Middle	, Maiden Suman	ne)	
yla	Ment Ment arked	James	S. Haywa	rd				Mary E.	. Weaver			
Maryland	U 00 -	19a. Intorment's Ne				19b. Mailing Address (Street e						
	1 and 1 Health Health trither tri	Martha Ha		ighter				ark Lane				
Baltimore,	0 = 0			Removel from Stete		20b. Plece of Disposition (Neme of cemetery, cremetory or other place) Metropolitan Crematory 8/21/98 Alexand					city or Town, Stete	
Balt	permit. Pa Depertmen important: any injury pnce.	21. Signature of Fu	nerel Service Lice	Har	diner	Mat	tingl	ress of Fecility ey-Gardin 270, Leon			-	
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	es that the deeth certigned by the ettendine be detached for use by Physician/W	Pert II. Other signifi	cent conditions	contributing to death b	ut not resulting	in the under	vina ceuse o	iven in Pert I.	23b. Dld	23b. Did tobacco use contributa to the cause of dea		
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ita	entifica ector, Be C	25. Wes cese reteri	red to medical					26. Plece of Death (Check		one)		
>	Physician: this certific ral director,	exeminer?	No	Hospital: 1 ☐ Inpatio	ent 2 ER/O	utpetient 3	DOA O	ther: 4 Nursing	Home 5 ☐ Res	dence 6 Oth	ner (Specify)	
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Divis	Hospital or Attending 24 hours efter death. Funeral Director: Attentiely filled in by the fune stely filled in by the fune	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, tectory, office building, etc. (Specify)							28f. Location (City or To	'Street and Numi wn, Stata)	ber or Rural	Route Number,
	To the Hospital or Attending P. within 24 hours effer death. To the Funeral Director: Affer the completely filled in by the funeral Medical Certification:	29a. Certifier (Check only one)	Certifying Pl	nyalclan: To the best niner: On the basis o end manner st	f examinetion e	e, death occ nd/or Investi	urred et the getion, In my	time, date end pled opinion, deeth occ	e, end due to the curred et the time,	ceuse(s) end made end place,	anner es ste and due to t	ited. the ceuse(s)
	within 2 To the comple	29b. Signeture end	title of certifier	1			29c. Licer	nse number		29d. Date signe		
			10000	idus.	7		Do	0882		8.50	.98	
		30. Name end eddre	ess of person who	completed cause of	leath (Item 23e)	(Type, Print						
		JOHN	LF. Fe	nuich,	m. T).		Leonardt	own, MD	20650		
	State Registrar	31. Date tiled (Mont	th, Dey, Year) 2 4 1998	32. Registr	er's Signeture	1. 1	rocks	,				
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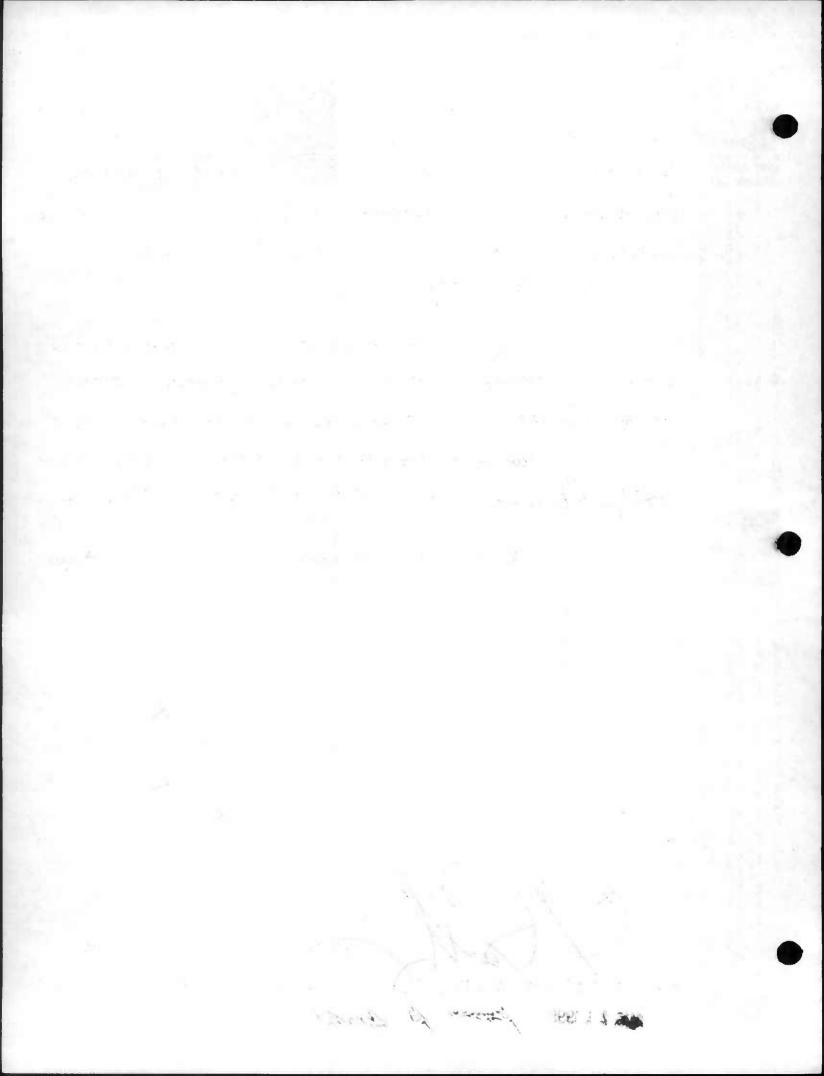
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		1. Decedent's Neme (First, Middle, Last	1)	Certificate of	Dealli	2. Dete of Deeth	g. No.	3. Tima of Death
Physici /Medic		Frank	Ernest	HELS	SEL	August	20, 1998	10:10 pm
Examir		4a. Facility Neme (If not institution, give 205 Saint Mark Wa			4b. City, Town, or L Westmins		4c. County of Deat	
Funeral Director		170 32-3419	MM OFF	ast birthday) If Undar 1 Ya Months De		8. Date of Birth (Month, Day, June 15,	year) 9. Birt 1912 Peni	thplece (State or Forei puntry) nsylvania
f show	or	Usual Residence of Decedent 10a. State 10b. County Maryland Carroll	The state of the s	r, Town or Location				10d. Insida City Limi
3a or 28a	Funeral Director	10e. Street end Number 205 Saint Mark Wa	ay, #317	10f. Zip Cod	21158	10	g. Citizen of Whet Co	ountry?
al', or items 23a or 28a-f show Exanyhar must be notified at	by	11. Marital Status 1 ☐ Naver Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decadent Ever In U, Armed Forces? 1 △ Yes 2 □ No 194 If Yes, Give Year or Dates: 196	Z-	of Hispenic Origin? (Sp cuben, Mexican, Puerto No Specify:	pecify Yes or No- Dican, etc.)	14. Reca - Ame Bleck, Whit Specify:	
Department of nearing and Mental hyglene. Important: If Item 27 is marked other than "natural", any injury or other traumatic event, its Medical Exp once.	Completed	15. Decedent's Edu (Specify only highast grad Elementery/Secondary (0-12)	College (1-4or 5+)	16a. Decadent's Usual Occ (Give kind of work do life. DO NOT use ref Chaplain/Col	orking		States Army	
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traumal		19e. Informant's Name/Reletionship (7) Mrs. Nancy Helsel		19b. Mailing Address (Stre 205 Saint Ma				
t: if item (20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donetion 5 Acthar (Specify)	20b. Pl	ace of Disposition (Name of amatery, crematory or other p	placa)	Date 2	Oc. Location - City or	Town, Stete
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pad	Be Com	25. Was case referred to medical			26 Place of Deat	t ☐ Yes	_	t ☐ Yes 2 ☐ No
0 0	ဥ	examiner? 1 Ves 2000 27. Manner of Death	28a. Date of Injury	Pr/Outpatient 3 DOA 28b. Time of Injury 28c. tr	Other: 4 Nursing Ho		ce 6 Other (Spec	cify)
After fune	Certification:	Natural 5 Pending investigation 3 Suicide 6 Could not be determined	(Month, Day Year) 28e. Place of Injury At ho building etc. (Specify	☐ Yes 2☐No	28f. Location (Street and Number or Rural Route Num City or Town, State)			
rector:			clany to the best of my kylon	edge seath occurred at the on a proof investigation, in m	time, date and place, y opinion, death occur	and due to the cau	se(s) and manner as e and place, and due	stated.
2		29a. Certifier (Check only 2 Medical Example only)	her: On the basis of examinate	Al				The mile commonstage
2	Medical Ce	29a. Certifier (Check only one) 29b. Signature and title of certifier	her: On the basis of examinat	N	ense number	29	d. Date signed (Mont	
To the Funeral Director: completely filled in by the	edicai		Tall	29c. Lice D3				h, Day, Year)

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

amend item 7 per fh G779 1/15/00 yg Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month 10:30 AM **Physician** Hock 4e. Fecility Name (If not institution, give street and number) 1998 August 20 /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 703 John Brown Lane
5. Social Security Number 6. Sex Knoxville Washington If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Sept 2 7. Age (In yrs. lest birthday) 9. Birthplece (State or Foreign **Funeral** 1□ M 2 F 230-48-8259 68-69 West Virginia Yrs. Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f ehow Examiner must be notified at MD Washington Knoxville Director 1 Tyes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 703 John Brown Lane USA Funeral permit. Pagas 1 and 2 should be filed within 72 hours after death 1 Department of Hastib and Mental Hygiana. Important: If Item 27 is marked other than "natural", or Items 23 any injury or other traumatic event, the traumatic avent, the traumatic manning manning injury or other traumatic event, the traumatic manning manning injury or other traumatic event, the traumatic manning manning injury or other traumatic event, the traumatic manning manning injury or other traumatic event, the traumatic manning manning injury or other traumatic event, the traumatic event in the property of the property in the property of the 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: by 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife Homemaker 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) James Enoch Nichols Hazel Gladys Smith 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 703 John Brown Lane, Knoxville, MD 21758 Timothy A. Moss 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 DBurial 2 Cremation 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Union Cemetery 8/24 Leesburg, VA 22 Name and Address of Facility

John 1. Williams Funeral Home

100 Petersville Rd Brunswick MD 21716 21. Signeture of Funeral Service Licensee Banbana A. Williams, Owner 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medicai Examiner Due to (or es e consequence of) Examiner physician and tha burial-transit tha daath certificata be axecuted Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Box 68760 Physician/Medical Due to (or es e consequence of): usa ó P.O. signed by the a d be deteched f Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by Records, 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed paga 2 s 1 ☐ Yes 2 No Division of Vital Hospital or Attanding Physician:
 24 hours aftar daath.
 Funeral Director: Aftar this cartifica lataly filled in by tha funeral director, p. 25. Wes cese referred to medicel examiner?

1 Yes 2 No Be 26. Piece of Deeth (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Naturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 Sulcide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 T Homicide Descripting Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier To the Hosp within 24 hor To the Fune complataly fi (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Dey, Yeer) Aug 21, 1998 30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print) 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 27034 State of Maryland / Department of Health and Mental Hygiene

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lica		KA	ATHLEEN	ELIZABET	'H	HUEG	EL		August	Day 18, 19	Yaar 998	2:15	AM	
ine	-							4b. City, Town, or		4c. County	of Death			
4		8623 Hunt Club Road Thurmont 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) If Under 1 Year If Undar 24 Hrs.						D. Date of Birth	Frederick					
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Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 7 Certificate of Death 1. Decedant's Nama (First, Middla, Las 2. Data of Death 3. Time of Death **Physician** Aymone 4b. City, Toym, or Location of Death /Medical 4a-Facility Nama (If not institution, giva street and number Examiner If Under If Under 24 Hrs. 9. Birthplace (State or Edmin) 5. Social Sacurity Number Age (In yrs. last birthday) **Funeral** Months Days 1 X M 2 □ F Yrs 009-22-0601 64 Director June Vermont Usual Rasidance of Dacedani 10c. City, Town or Location 10b Counts 10d. Inside City Limits 1 ☐ Yes 2 No Director Prince George's 28a-f Maryland Clinton 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? "natural", or Itama 23a or 7002 East Clinton Street 20735 U. S. A. Funeral 14. Race - American Indian, Black, Whita, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 1 Ny Yas 2 No
If Yes, Giva
Year or Datas: 1953-62 1 ☐ Nevar Married 2 ☑ Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada completed) Prince George's Co. Elementery/Secondary (0-12) Collega (1-4or 5+) Public Schools Foreman 17, Father's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surnama) Be permit. Pages 1 and 2 should be I Department of Health and Mental I Important: If Nem 27 is marked of any Injury or other traumatic eve MARLAND FREEMAN GENEVEVE IBEY 19e. Informent's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Janet L. Ibey/Wife 7002 East Clinton Street, Clinton, Maryland 20735 20b. Place of Disposition (Name of cemetary, crematory or other place) 20c. Location - City or Town, State Data 1 Bury 2 X Cremation 4 DDo 5 Other (Spec THE HUNTT CREMATORY 08-24-1998 WALDORF, MARYLAND 22. Nama and Address of Facility The Huntt Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximete Intarvat Between Onset and Death **Physician** /Medical Immediata Causa (Final PROSTATTE CANEGE disaasa or condition rasulting in daath) Examiner Dua to (or as a consequence of) Examiner Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Disaese or injury that initiated evants resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria P.O. Box 68760 Physician/Medicai Dua to (or as a consequence of). Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Hunknown Division of Vital Records. p 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director: After this certifics Be 25. Was casa rafarred to medical axaminer? 26. Place of Death (Check only one) 1 Yas Other: 4 ☐ Nursing Homa 5 ☐ Residence 6 ☐ Other (Specify) € Inpatient 2 ER/Outpatient 3 DOA edical Certification: To Mennar of Death 28d. Describe how injury occurred 28a. Deta of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Panding 1 Yes 2 No Invastigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stele) 28a. Ptece of Injury - At home, ferm, street, factory, office building, atc. (Specify) completely filled in by 4 Homicida within 24 hours a To the Funeral D reflying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) manner stated. 29a. Cartifier 29b. Signatura and title of certifie 29c. License number 29d-Data signed (Month, Day, Year)

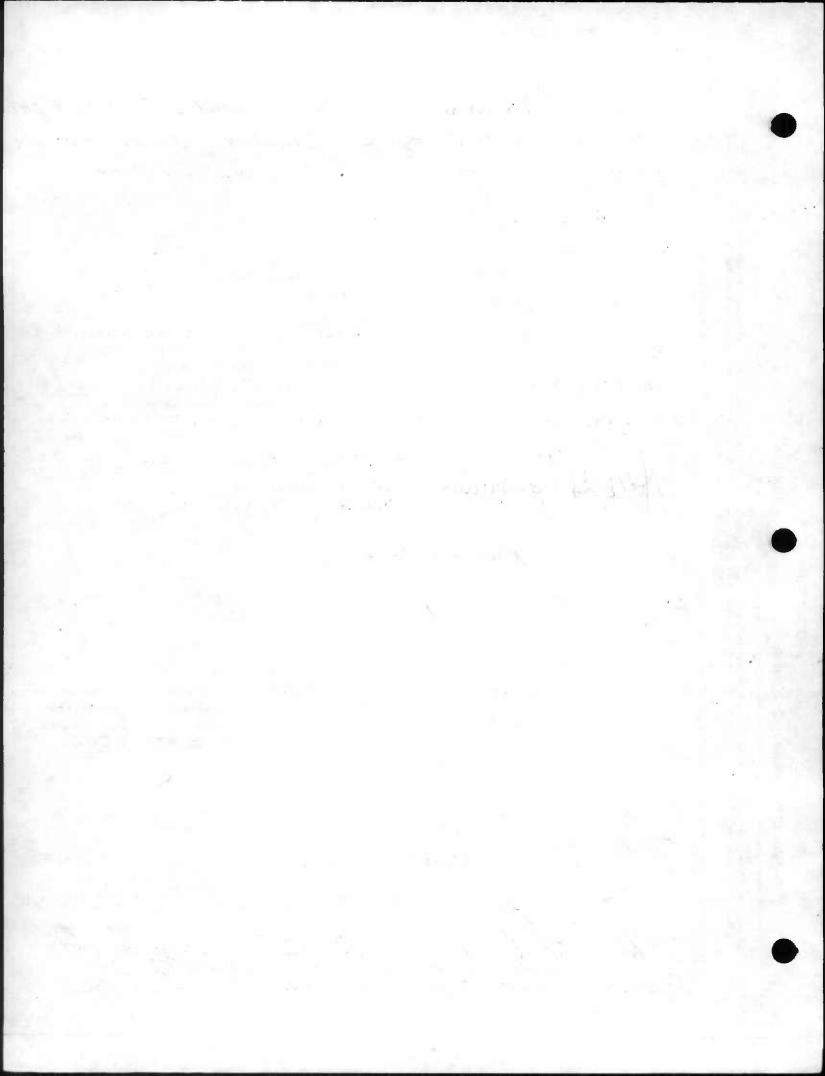
State Registrar 31. Data filed (Month, Day, Year)

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DHMH 16 Rev 6/95

30, Nama and addrass of person who completed causa of death (Item 23a) (Type, Print)

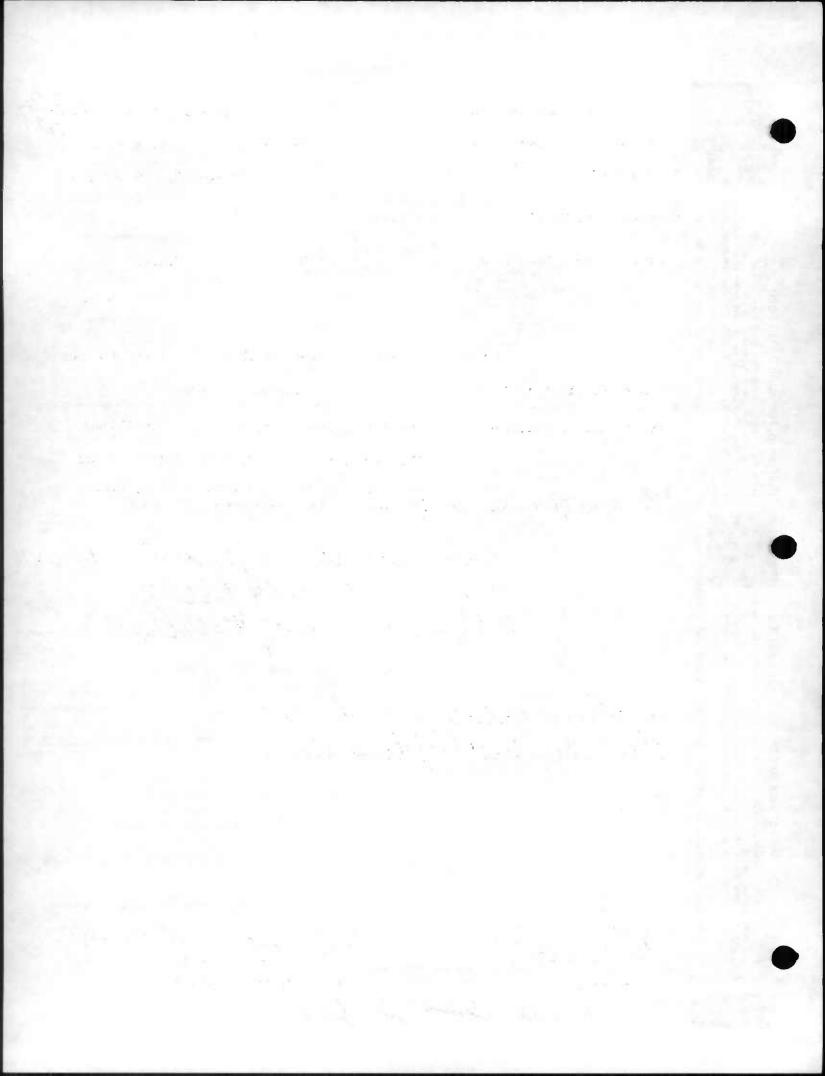
32. Registrar's Signature



Please Type or Print in Black indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 27036

		Certificate of Death	Reg. No.	_ 7000		
		1. Decedent's Name (First, Middle, Last)	2. Dete of Deeth Month Dey Year	3. Time of Deeth		
	Physician /Medical	Flowers Deceles Tables	August 14, 1998	1000		
	Examiner	4h City Tourn of	ocation of Deeth 4c. County of Dee	th AM		
		24480 Mervell Dean Road Hollywo				
	Funeral Director	5. Social Security Number 213-38-2347 G. Sex 1 M M M P F M Months 7. Age (In yrs. lest birthday) 1 Yrs. 7. Age (In yrs. lest birthday) 1 Yrs. 1 Months 1 Deys 1 Min. 1 Min.	8. Dete of Birth (Month, Dey, Yeer) 9. Bir Co	thplece (Stete or Foreign ountry) aryland		
	puel #	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits		
	Mary Med and	Maryland St. Mary's Hollywood		1 ☐ Yes 2 No		
	after death with the Maryler or Hems 23a or 28a-f show infiner must be notified at / Funeral Director		10g. Citizen of Whet Co	ountry?		
5-0020	D	11. Meritel Status 12. Wes Decedent Ever in U,S. Armed Forces? 1 Never Merried 2 Married 1 Never Merried 2 Married 3 X Widowed 4 Divorcad 12. Wes Decedent Ever in U,S. Armed Forces? 1 Never Merried 2 Married 1 Never Merried 3 Married 1 Never Merried 3 Married 1 Never Merried 2 Married 1 Never Merried 3 Married 1 Never Merried 3 Married 1 Never Merried 3 Married 1 Never Merried 4 Divorcad 1 Never Merried 5 Married 1 Never Merried 6 Married 1 Never Merried 7 Never Merried 9 Married 1 Never Merried 9 Married	pecify Yes or No- Bleck, White			
5-0	natural,	15. Decedent's Education (Specify only highest grede completed) (Give kind of work done during most of work life. DO NOT use retired)	16b. Kind of Business	/Industry		
21	c - 2	Elementary/Secondary (0-12) College (1-4or 5+)				
121	offied within the property of	2 yrs Elementary School Teac		chool		
and	d out	ž į	ne (First, Middle, Maiden Sumeme)			
	d 2 should be filed the marked other traumatic event.					
Mary	12 sho h end is me traum	19e. Informent's Name/Relationship (<i>Type, Print</i>) 19b. Meiling Address (<i>Street end Number or Ru</i>	ral Houte Number, City or Fown, Stete,	Zip Code)		
	s 1 and if Health Item 27 other tr	Norma I. Dawson/Daughter 24480 Hollywood Road. 20e. Method of Disposition (Name of	Hollywood, MD 206 Dete 20c. Location - City or			
Baltimore	or of	1 N Burial 2 Cremetion 3 Removel from State cemetery, cremetory or other piece)				
tim	nit. Pagartment ortant: I ortant: I Injury o		8/17/98 Hollywood	, MD		
Bal	permit. Par Department Important: any Injury once.	21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility Mattingley-Gardine	r Funeral Home, P.	Α.		
	00240	23a. Part1. Enter the disease, of complications that caused the death. To not enter the mode of dying, such as cardlac shock, or heart failure. List only one cause on each line.	rdtown, MD 20650			
	DESCRIPTION OF THE PERSON NAMED IN	23a. Part1. Enter the disease, of complications that caused the death. 66 not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiretory errest,	Approximete Intervel Between Onset end Death		
	Physician /Medical Examiner	Immediate Ceuse (Final disease or condition resulting in death) Due to (or es a consequence of):	failul	Month		
Box 68760,	o certificate be executed inding physician end use as the burist-transit in Medical Examiner	Ceuse (Disease or injury that initieted events resulting in death) Lest	enerolized			
	death e atte	Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I.	23b. Did tobacco use contribut	e to the cause of desth?		
s, P.O	ires that tha death certi signed by the attending d be datached for use a d by Physician/M	Chronic Brain Syndione		Probably 4⊠Unknown		
Records,	aw requisite been 2 shoul	due sto multiple strokes	24a. Wes en eutopsy performed?	Were eutopsy findings evaileble prior to completion of cause of deeth?		
H		§	1 ☐ Yes 2 No	1 ☐ Yes 2 ☐ No		
Vital	certificate rector, pag	25. Wes case referred to medical exeminer?	th (Check only one)			
2			ome 5 Residenca 6 Other (Spe	ecify)		
E	on:	27. Menner of Deeth 28e. Date of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury et Work?	28d. Describe how injury occurred			
Division of	To the Hospital or Attending Ph within 24 hours after deeth. To the Funers! Director: After th completaly filled in by the funera! Medical Certification: "	2 Accident investigetion 3 Suicide 6 Could not be determined 28e. Plece of Injury · At home, farm, street, factory, offica building, etc. (Specify)	28f. Location (Street end Number or Fi City or Town, Stete)	lurel Route Number,		
	To the Hospital or within 24 hours after to the Funersi Dir completaly fillad in Medical Cert					
	Me the	29b. Signatury and title of certifier 29c. License number	29d. Date signed (Mon	ith, Dey, Year)		
		30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)	8.77.	48'		
		Abdussamed Samadi, MD Leonardtown	, MD 20650			
	State	21 Date field (Month Day Vers)	,			



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State of Maryland / Department of Health and Mental Hygiene 9 8 27 0 3 7

						Certific	ate of	Death		Reg. No.	61001	
	Dhualaia		1. Decedent's Neme (First, Middle, La	st)					2. Date of De Month	Dey	Year 11.14 On	
	Physicia /Medica	_	THEODOKE	PERCY	JEN	ITER			AUG	UST 09,	1998 11.15511	7
	Examine	er	4e Facility Neme (If not institution, giv	. /				4b. City, Town, o	r Location of Deat		/	4
					SPITAL		nder 1 Year	If Under 24 H	E O DOLO OF DE		CF GEORGES	>
	Funeral			Sex 7. Age	(In yrs. last L	Yrs. Mont		Hours Mi	n. (Month, Da	ay, Year)	9. Birthplace (State or Foreign Country)	gn
ч	Director	-	578-40-3520 Usuel Residence of Decedent		68				05/1	0/30	Washington, D	ال
	show		10a. Stete 10b. County		10c. City, To	wn or Location					10d. Inside City Limit	
	the Mar 28a-f a	cto	MD Prince G	eorge's	Ch	everly					1 1 Yes 2 □ N	ю
	or 28	e l	10e. Street and Number			10f.	Zip Code			10g. Citizen of W	/hat Country?	
	after deeth with the Maryland or Nems 23a or 28a-f show other mast be notified at	Funeral Director	1713 62nd Avenue				2078			United		
	items items	Lu	11. Meritel Stetus	12. Wes Decedent E Armed Forces?		13. Wes Do	ecedent of h specify Cub	lispanic Origin? an, Mexican, Pue	(Specify Yes or No orto Rican, etc.)	14. Race Blec	e - American Indien, k, White, etc.	
20		by F	1 ☐ Never Merried 2 ☐ Merried 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 N If Yes, Give Yeer or Detes:	ю	1□ Ye	s 2 10 No	Specify:		Specify		
21215-0020	"natural", or the	8	15. Decedent's E		16	a. Decedent's t	Jsuei Occur	pation		16b. Kind of Bu	Afro-American	1
215	c 1 8 4	Completed	(Specify only highest gra Elementery/Secondery (0-12)		4)	(Give kind of life. DO NO	work done Tuse retire	during most of w d)	orking			
21	d with giene. r than	E	12th	4+	*)	Tea	cher			Educ	cation	
	e filed al Hygi other vent,	Be	17. Fether's Neme (First, Middle, Last)				18. Mother's N	ame (First, Middle	, Maiden Surnam	9)	
Maryland	2 should be filed within and Mentel Hygiene. In marked other than aurmatic event, the Mentel Brown, th	0	Theodore Jenifer	r, Sr.				Glady	s Thomas	5		4
lar	2 4 5 6		19e. Informent's Neme/Reletionship (The state of the s					Rural Route Numb		State, Zip Code)	
	f and Heelth em 27 other tr	-	Gwendolyn H. Jer	ifer (Wife					everly, N			
altimore,	of the		20e. Method of Disposition 1 ☐ Burial 2 X Cremetion 3 ☐	Removel from Stete	cemel	ol Disposition (tery, crematory	or other pla	ce)	Date	20c. Location -	City or Town, Stete	
‡	ir. Perintmen	-	4 Donetion 5 Other (Specif		Nort	hern Vi				Arlingt	ton, Virginia	
Bal	Department Department Important: I any injury o		21. Signature of Funeral Service Lice	m 11.11	1016	Dud 1	e end Addre .ey Fu	neral Ho	ome			
	40549		Cuawara W.	Dudley Y	mass	3200	Rhod	e Island	Ave., N	1t. Raini	ier, MD 20712	
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		ē			Due to (or es	e consequence	of):					
	uted d ansit	Examiner	Convention to the same distance	b	Due to for es	e consequence	W.				1	
o,			Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury	Dellas.			.,.					
68760,	te be nysicii	edica	Ceuse (Disease or Injury that initiated events resulting in deeth) Lest	c	Due to (or es	a consequence	of):					
2.4	ng pt	8	resulting in deetin) Lest								1	
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0.	the attenthed for u	Physician	Part II. Other significant conditions of	ontributing to death bu	t not resulting	in the underlyi	ng cause gi	ven in Pert I.	23b. Did	tobacco use cor	ntribute to the cause of deat	h?
P.	that the death cered by the attendir detached for use								1 🗆	Yes 2 No	3 Probably 4 Unkno	nwc
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0	been sign should be	Completed								omed?	available prior to completion of cause	3
360	9 8 8	ğ.	•								of death?	
	cate h								10	Yes 2 No	1 ☐ Yes 2 ☐ No	
Vital	Physicien: The this certificate ral director, pag	200	25. Wes case referred to medical examiner?	Hospitel:			Ott	hor	eeth (Check only			
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on	ding th. Afte	20	1 Neturel 5 Pending investigation	28a. Dete of Injur (Month, Dey	Year)	Injury M		rk? Yes 2 □ No				
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á	after a after I Direct	Certification:	4 Homicide	building, etc	. (Specify)				City or To	wn, State)		
				yalclan: To the best o								
	the H hin 24 the F	edica	one) X Medical Exam	end manner ste		und/or investiga			corred at the time.	11,13-11, -02-	and due to the cause(s)	
	To T To T	Σ	29b. Signeture and title of certifier	ALL IN	1		29c. Licen:	se number		29d. Date signed	d (Month, Day, Year)	
	=		Mound	THUT	>//w/	DME	73	3954		AUGUST	13, 1998	
	(10)		30. Neine and address of person who	1.1	aty (Item 23a		11 100	J	21.40	614-0	MARYLAND 20	74-
	10		11 AV O T. GO 31. Dete filed (Month, Dey, Year)		M	3001	HOSP	TAL DI	que, oh	EVEKLY,	IMAKYUAN'N . M	185
	State		St. Dete med (Month, Dey, Tear)	32 Hegistre	r's Signeture	6 1				·		

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FR	RANKLIN J	ONES		State	of Marylar		artmen					iene	61	000	
			ame (First, Middle,	Last)						2	. Dete of Deet	h	Vana	3. Time of	Death
	Physician /Medical		n Frankli	n Jones	Jr.					A	Month UGUST	Dey 16, 19	Yeer 198	1151	AM
	Examiner	An Panille, Man.	e (If not institution, g	rive street end nu	ımber)			4	\$b. City, To	wn, or Loca	tion of Deeth	4c. County			
			GEORGES I		_		. Without		CHEVE					orge's	
	Funeral	5. Sociel Securit 249-70-5		Sex 1□XM 2□ F	7. Age (in yrs.		Months Months	Deys	If Under Hours	Min.	Date of Birth (Month, Dey,	Year)	9. Birthp	lece (Stete o	or Foreign
Ш	Director	Usuel Residence			54	4				De	ctober	8, 194	3 501	ith Ca	rolin
	yland	10e. State	10b. County			ity, Town or L	ocation		_				1	0d. Inside C	Ity Limits
	Man Man	Maryland	Prince	George'	S			Land	dover					1 Yes	2 ☐ No
	72 hours efter death with the Maryland natural; or items 23a or 28a-f show acal Examiner must be notified at the death of the choice of the ch		Number Landover	Road, #E			10f. Zip	Code	2078	5	1	Og. Citizen of V	Whet Cour USA	itry?	
	free death v r frems 23a niner mant	11. Meritel Statu	ıs	12. Wes Dec	cedent Ever in U	J,S. 13.	Wes Deced	dent of H	ispenic Ori	igin? (Speci	fy Yes or No- can, etc.)		e - Americ	an Indian, etc.	
21215-0020	al', or he	3 ☐ Widowe	larrled 2□ Married d 4 MgDivorced		2X No		1□ Yes		Specify:			1 20	Bla		
5-0	be filed within 72 hours half Hyglena. Ind other than "natural", event, the Modical Exa	(S	15. Decedent's pecify only highest of	Education)	16a. Dece	edent's Usua	el Occup	etion du <i>n</i> na mos	at of working	,	16b. Kind of Bu	usiness/în	dustry	
12	within ena.	Elementery/S	econdary (0-12)		(1-4or 5+)	life.									
	Hygier the		2th ne (First, Middle, La	ot)			Pai	inte		or's Nama (First Middle A	Pr Meiden Sumer	ivate	9	
and	Mental F Mental F arked out attc ever	-	on Jones	5()					TO. NOTH		ary Jan		10)		
Maryland	d 2 should be filed then the end Mental Hygin 7 is marked other traumatic event, To Re Cr		Name/Reletionship	(Tyne Print)		19h Mell	ing Address	s (Street	end Numbi			, City or Town,	Stete Zin	Code)	
E	trau		Jones Tho		er		_					rer, Ma			85
ē,	~ # E E	20e. Method of I	Disposition		20b.	Plece of Disp	osition (Ner	me of				20c. Location -	-		
9	00-5		2 ☐ Cremation 3 on 5 ☐ Other (Spe		State	armony				8/2	22/98	Landov	er. N	Marvla	nd
Baltimore,	permit. Pag Department Important: if any Injury o		Funerel Service Lic				2. Name er						,_	7	
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	Physician /Medical Examiner	Immediate Ceur diseese or cond resulting in deet	se (Final	. 14	enop	ty Si &	an	1	topi	y tri	or of	Bloc	bel	Onset end	Deeth
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P.0	igned by the elbe datached by Dhysic										1 🗆 Y	●● 2□No	3□ Pro	bably 3	Unknown
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	Jing After fune									ld. Describe ho	ow injury occur	red			
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	Hospi 24 hou Funer stely fill			Physician: To the arminer: On the bend man											s)
	To the comple		and title of certifier Au	Lov	ken	20	296	c. Licens OCME	e number			9d. Dete signe UGUST]			
	3		ddress of person wh												
			on Locke I		111 Pe		reet,	Balt	imore	e, Mai	ryland	21201			
	State	U. Date thed (iv	0. 1000	And a die											

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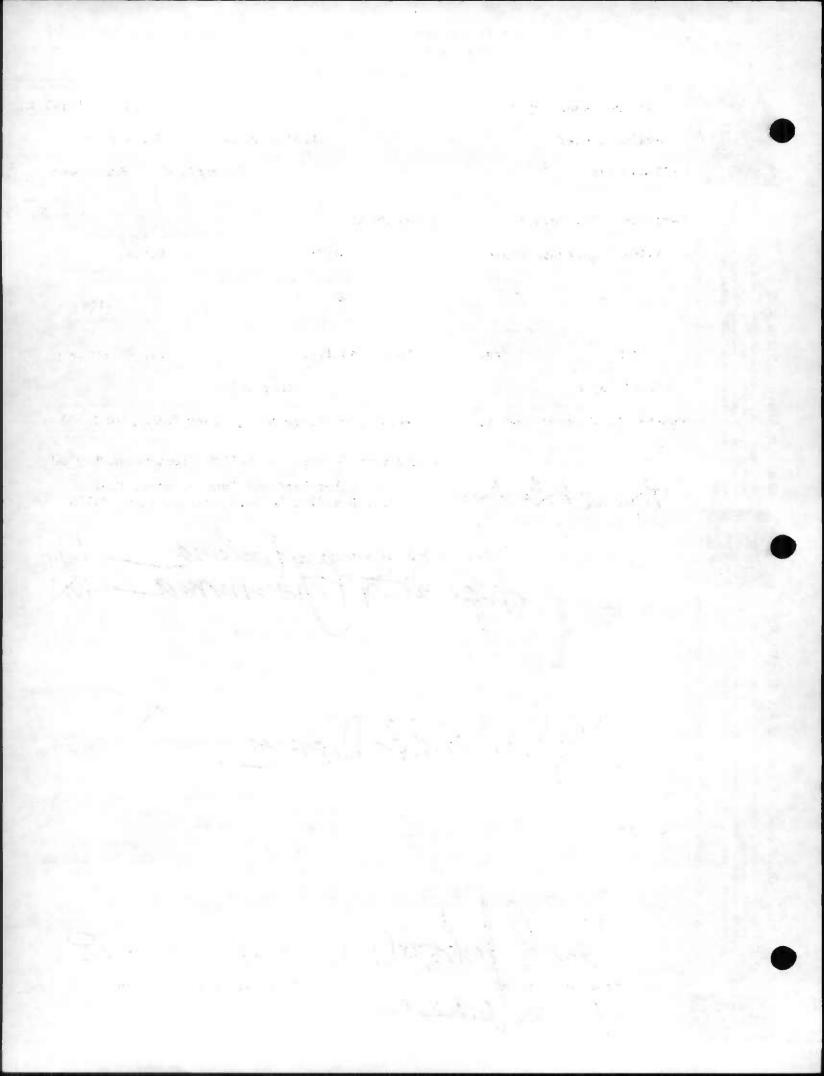
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gregorie Element

Appendix and the second
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							Cel	rtificate of	Deati	1		Reg. No.		
Physician		Decedent's Nam		die, Last) es Joyc							2. Date of De Month Augus	Day	Yeer	3. Time of Death 12:45 AM
/Medical	0.0	Facility Name (nber)			4b. City, T	Town, or Lo	cation of Deat		y of Death	12.43 Kil
Examiner		Bayside							Lexi	ngtor	Park	St.	Mary	's
uneral irector		Social Security N		6. Sex	2 F	7. Age (In yrs.	last birthday) 77 Yrs.	if Under 1 Yea Months Day		Min.	8. Date of Bir (Month, Da January	th Year) 4, 1921	9. Birthp Cour Penns	elace (State or Foreign etry) sylvania
3		sual Residenca o la. State	Decedent 10b. Count	hv .		10c Cits	y, Town or Lo	ocation					1	0d. Inside City Limits
of Po		aryland		Mary's			Piney 1							1 □ Yes 2 No
28a- north	10	e. Street and Nu		nary s			i liley .	10f. Zip Code				10g. Citizen of	What Cour	ntry?
Sa Di		44765	Lighth	nouse R	oad			206				U.S	. A .	
'natural', or flems 23a or 28a-f show adical Examiner must be notified at leted by Funeral Director	11	. Marital Status 1 Never Marr 3 Widowed	ried 2□ Ma	12. W Ar		2 □ No e		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☑ N			ecify Yes or No Rican, etc.)	Speci	ce - Americack, White,	etc.
		Elementary/Seco	cify only high ondery (0-12)		pleted) ollege (1-		(Give life. I	dent's Usual Occ kind of work don DO NOT use reti	e during mo red)	ost of work	ing	16b. Kind of E		
event, tre		12th			Yrs		Bud	get Anal	4	hada Nam	/Circl Adiddle	U.S. Maiden Suma		rnment
aumatic event, trail		Edward		s, Last)						ary S		, Maideil Sullia	me)	
if item 27 is marke or other traumatic TO		9a. Informant's N		ship (Type, P	rint)		19b Mailir	ng Address (Stre		-		er. City or Town	. State. Zic	Code)
27 Is trau	1	ynthia I				er		65 Light						
Itam 27 other tr		a. Method of Dis	position			20b. P		osition (Neme of matery or other p			Date	20c. Location		
ry or		1 ☑ Buriai 2 4 ☐ Donation			al from S	otate		norial Gar		18	/5/98	Leonard	town. N	Maryland
important: if item 27 is marked other any injury or other traumatic event, if pncs. To Be Co		1. Signature of Fu	neral Service	License	. 1:		22 M :	Name and Add	ress of Faci	dine:	Funer	al Home	, P.A	
sician edical aminer	In	nmediate Ceuse	(Final	or complication st only one cau	ns that cause on ee	aused the death	P	O. Box er the mode of d	270,	Leona as cerdiec	ardtown or respiratory e	, Maryl	and 2	Approximete Interval Between Onset and Death
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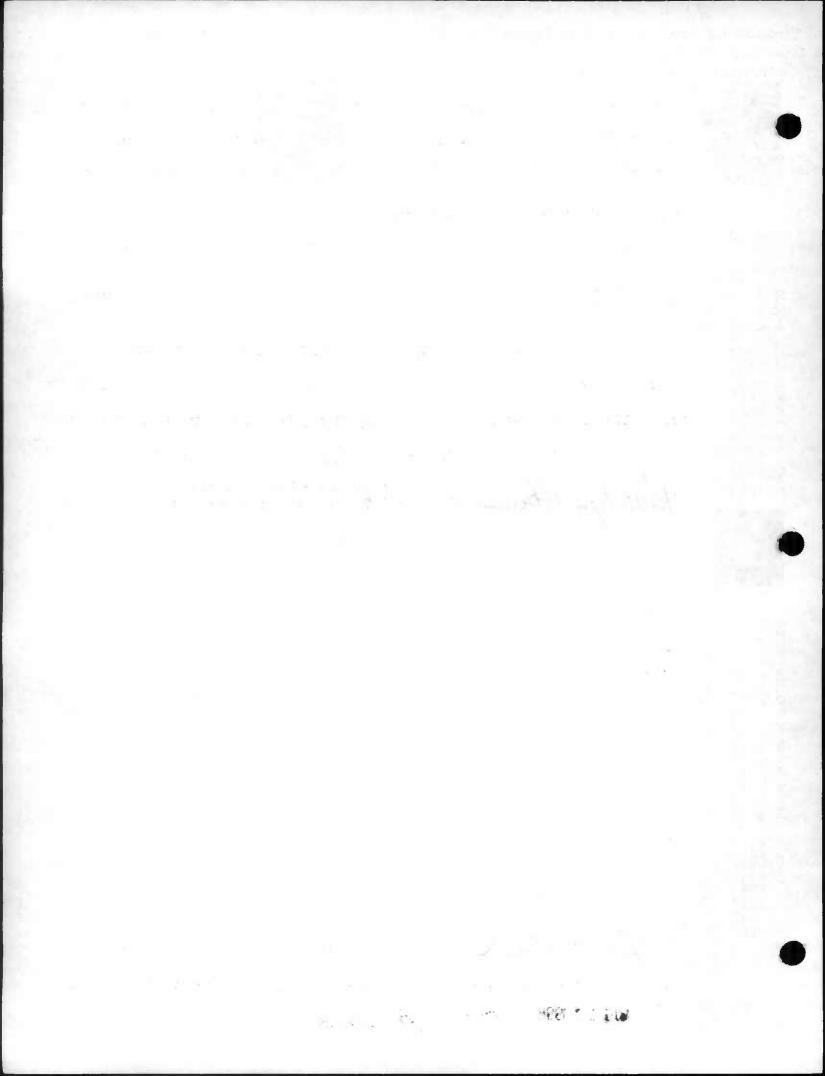
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State of Maryland / Department of Health and Mental Hygiene 27040

						Death	-	leg. No.		
	don	1. Decedent's Neme (First, Middle, La	st)				2. Dete of Dee Month	th Dey	Voor	3. Time of Deeth
Physic /Med		Robert	Shepher	d	JAQUES		August	14, 19	998	7:50 pm
Exam		4e. Fecility Name (If not institution, giv Northampton Mand		Center		4b. City, Town, or Freder	Location of Deeth	4c. County	of Deeth ederi	ck
Funeral Director		447-30-7310	ex 7. Age (//	n yrs. lest birtho 91 Yrs	Months Days			1906	9. Birthp Coun Can	lece (State or Foreig try), ada
Maryland a-f ahow	tor	Usuel Residence of Decedent 10a. State 10b. County Maryland Freder		oc. City, Town o					1	0d. Inside Clty Limits
iter death with the Marylan items 23a or 28a-f show ner must be notified at	Funeral Director	910 Young Place			10f. Zip Code	21702	1	0g. Citizen of V	Whet Coun	try?
within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28s-f show he Medical E-samine: must be notified at	by	11. Maritel Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Wes Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates:	r In U,S.	13. Was Decedent of If Yes, specify Cul	ben, Mexican, Puer	Specify Yes or No- to Rican, etc.)		e - Americ ck, White,	
72 ho	eted	15. Decedent's Ed (Specify only highest gre	lucation de completed)	16a. De	ecedent's Usuel Occu	petion during most of wa	rkina	16b. Kind of Bu	usiness/Inc	dustry
	Completed	Etementary/Secondary (0-12)	College (1-4or 5+)		Give kind of work done fe. DO NOT use retin LSCOpal Pr			Religi	on	
Hy the		17. Father's Neme (First, Middle, Last)	/		-	18. Mother's Ne	me (First, Middle, I	Maiden Sumern	ne)	
0 5 0 0	To Be	Robert Herber	t JA	QUES		Ann	Be1			SHEPHERD
2 2 2 2		19a. Informent's Neme/Reletionship (1 Mr. William L. Ja			Address (Street) Young Pl.					
permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other to once.		20a. Method of Disposition 12 Burial 2 Cremetion 3 2 4 Donetion 5 Other (Specify	Removal from State	cemetery,	isposition (Name of cremetory or other pla La Lawn Cer	metery	Removal	St. Cat	City or To	wn, Stet Canadanes, Onta
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fing Physicien: The law requires that the d n. After this certificate has been signed by the funeral director, page 2 should be detached	To Be Completed by Physician	Pert II. Other significant conditions of the con	d	2 ER/Outpe	etient 3 DOA of the of your party.	26. Ptece of De	1 You eth (Check only on	n eutopsymed?	24b. We ever corror of c	pre autopsy tindings sileble prior to repletion of cause deeth?
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Registrar

AUG 1 7 1998



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/Medical Examiner Funeral irector	4e Fecility Name (If not institution, girl JOHNS HOPKINS	fano Kassa				AUG.	27, 199	8 Year	0257 AM	
_	JOHNS HOPKINS	ve street and number) HOSPITAL F	E.R.		4b. City, Town, or I BALTIM	ocation of Deet ORE	th 4c. County Balti	of Death Imore	City	
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sd at or	Usuel Residence of Decedent 10a. Stete 10b. County Maryland Baltim	ore City	10c. City, Town					10	od. Inside City Limits	
Se or 28s-f set be notified	10e. Street end Number 914 N. Charles		barcan	10f. Zip Co			U.S.A.	What Count	ny?	
Examiner must Examiner must by Funeral	11. Marital Status 1 Never Merried 2 KMarried 3 Widowed 4 Divorced	12. Wes Decedent Armed Forces? 1 Yes 2 If Yes, Give Yeer or Dates:		13. Was Deceden If Yes, specify 1 Yes 2	t of Hispenic Origin? (S Cuban, Mexicen, Puert No Specify:	pecify Yes or No o Rican, etc.)		ce - Americe ck, White, e		
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ector: After this by the funerel di tification: To	27. Menner of Death 1 X Naturel 5 Pending 2 Accident Investigation	28e. Dete of Inju (Month, De	ry 28b.		Injury et Work?		how injury occur			

Medical Certif

To the Hospital or Att within 24 hours efter d To the Funeral Direct completely filled in by 9

29a. Certifier (Check only one) Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) and manner as stated.

2004 Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner stated.

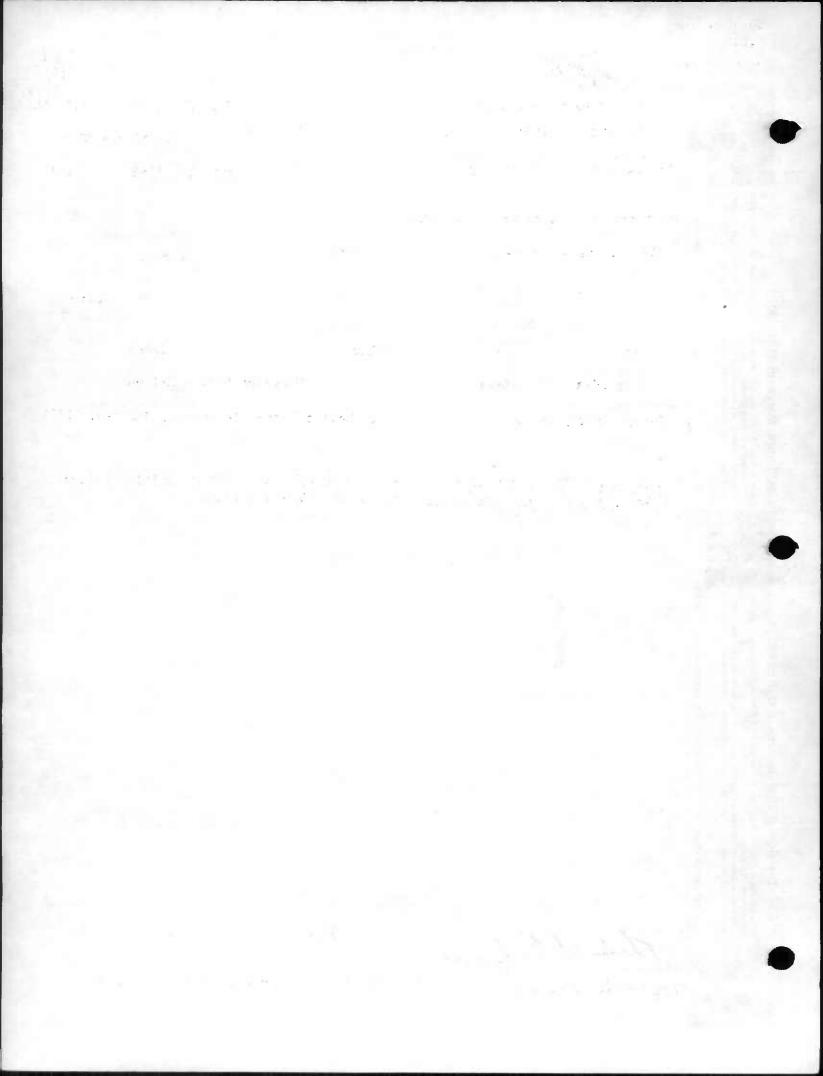
29d. Date signed (Month, Dey, Yeer) AUG • 27, 1998 29c. License number O.C.M.E

30. Name end eddress of person who completed these of death (item 23e) (Type, Print)

THE OORE M.
31. Date filed (Month, Day, Year)
SEP 4 1 111 Penn Street, Baltimore, Maryland 21201

State Registrar 32. Registrer's Signeture

5. Sports



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Daath 3. Tima of Death Month reddie 0 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death 5. Social Security Number 6. Sax Battomere Shock I rown Center Hours Min. 8. Data of Birth (Month, Day, Ye 5-12-44 If Undar 1 Yaar Birthpleca (Stata or Foreign Country) 7. Aga (In yrs. last birthday) Months Days 1MM 20 F 248-78-1048 54 SOUTH CAROLINA Usual Rasidance of Decedent 10a. Stata 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 X Yas 2 □ No PRINCE GEORGES BOWIE 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Coda 12706 LODE ST. 20706 UNITED STATES 14. Race - Amarican Indian, Black, Whita, atc. 12. Was Decedant Evar in U.S. Was Decedant of Hispanic Orlgin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status 1 Yas 2 No If Yas, Giva Yaar or Datas: 1 Navar Married 2 Married 1 Yas 2 No Specify: BLACK Specify: 3 Widowed 4 Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Spacify only highast grada completed) 16b. Kind of Businass/Industry Etementery/Secondary (0-12) Collega (1-4or 5+) TRAILER CLEANER PRIVATE 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) MACK W. KENNEDY NAOMI COUSAR 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) RHODENIA KENNEDY / SISTER 407 PRARIE CT. UPPER MARLBORO, MD 20772 20a. Mathod of Disposition 20b. Placa of Disposition (Nama of cematary, cramatory or other place) Data 20c. Location - City or Town, Stata tX Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata HARMONY MEMORIAL PARK 8-22-98 LANDOVER, MD 4 Donation 5 Othar (Specify) Funeral Service Ligensee 22. Nama and Addrass of Facility ALEXANDER S. POPE FUNRAL HOME 2617 PENN. AVE S.E. WASHINGTON DC 20020 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one ceuse on each line. Approximata Interval Batwaan Onsat and Death Immediate Causa (Finat ni adi disaasa or condition resulting in death) subdura Sequentielly list conditions, if any, taading to immadiate causa. Entar Undarlying Causa (Disaasa or injury that initiated avants rasulting in death) Last Dua to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 X No 1 ☐ Yes 1 TYAS 2 No 25. Was case ratarred to medical axanchar? 26. Place of Death (Check only ona) Othar: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 Yas 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA

/Medical Examiner the buriel-transit end physician P.O. Box 68760 certificate be SE the signed by t Division of Vital Records, page 2 : hes certificete director, this funeral After death. Hospital or Attendi
 24 hours efter death
 Funeral Director: A

Examiner Physician/Medicai þ Completed Be 2 Certification:

Physician

/Medical

Examiner

Director

Funeral

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Funeral

Director

jiene.
Than "natural", or items 23a or 28a-f shew, the Medical Examiner must be notified at

permit. Peges 1 and 2 should be filed within 72.
Department of Heelth and Mental Hygiene.
Important: if Item 27 is marked other than "na any Injury or other traumatic event, the Mode ones.

Physician

the

deeth

Baltimore, Maryland 21215-0020

27. Manner of Death 1 Defure 2 Accidant 3 Suicida 4 Homicide

29a. Certifier

To the Hosp within 24 ho To the Fune completely f

State Registrar

edicai

5 Pending invastigation

Dete of tnjury (Month, Daly Year) 8/15/98 6 Could not be

Injury 28e. Plece of Injury - At home, farm, streat, factory, office building, etc. (Specify)

Home

28b. Time of 11:00 PM 28c. Injury at Work? 1 Yas

2 No

28d. Describe how Injury occurred and

head hit 281. Location (Streat and Number or Rural Routa Number, City of Igwn, State) Street Bowie Md

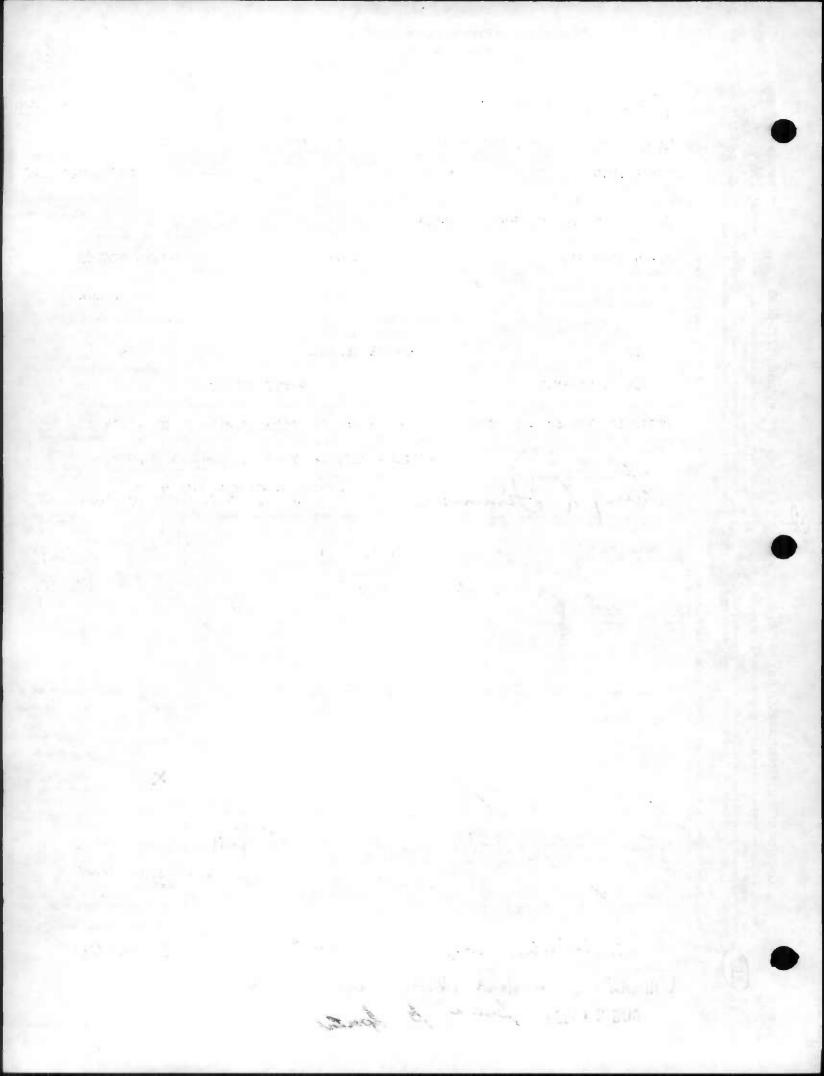
1 Certifying Physician: To tha best of my knowledge, daath occurred et the time, date end plece, and due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signatura and titla of certifian

MI

29c. Licansa number 3052 29d. Data signed (Month, Day, Year)

30. Name and addrass of person who completed ceuse of deeth (Item 23a) (Type, Print)

Mary land 31. Data filed (Month, Buy, Year) 32 Registrar's Signature AUG 2 1 1998



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Div.	Dir.	4 Homicide	35.5	building,	etc. (Specify)				City or To	iwn, State)			
spita	ours fille	29a. Certifier	1⊠ Certifying Pi	hysician: To the be	st of my knowledg	e, death occurre	ed et the tir	ne, date end p	plece, end due to the	ceuse(s) and m	anner as s	ated.	
T O	within 24 hours aftar death. To the Funeral Director: Aftar this cartificate has completely filled in by the funeral director, page 2 Medical Certification: To Be Comp	(Check only one)	2☐ Medical Exa	mine: On the basis and manner	of examination a	nd/or investigati	on, in my o	pinion, deeth	occurred et the time	, date and place	and due to	the cause	(s)
o th	Ne the	29b. Signature at	d title of confider	taraer c	RITICON (CANE 2	29c. Licens	e number		29d. Date sign		Dey, Yeer)	
	2 - 0	Huge	our 4		CONS	MAN	D3	e number		AUGU.	57 1	191	1478
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		1111	CEWORA	K. SAXE	WA, My	7100	DEED	GIHE	SING CO SDA M	1 708	17		
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								Death			Reg. No.		
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Funerai	Г		6. Sex	7. Age (In y	rs. last birtl	hday) if Ur Mont	nder 1 Year	if Under	24 Hrs.	8. Dete of Birt	h		piace (State or F
Director		211-07-9427 Usual Residence of Decedent	1 ⊠ M 2□ F	83	У	rs. Mont	tris Days	Hours	Min.	(Month, Day Feb. 10	, 1915		ryland
show		10a. State 10b. County		10c.	City, Town	or Location						1	0d. inside City
the Mar	Director	Maryland Freder	rick	Fr	ederi		. Zip Code	٠			10a. Citizen of	What Cour	1 Yes 2
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James D. Steward

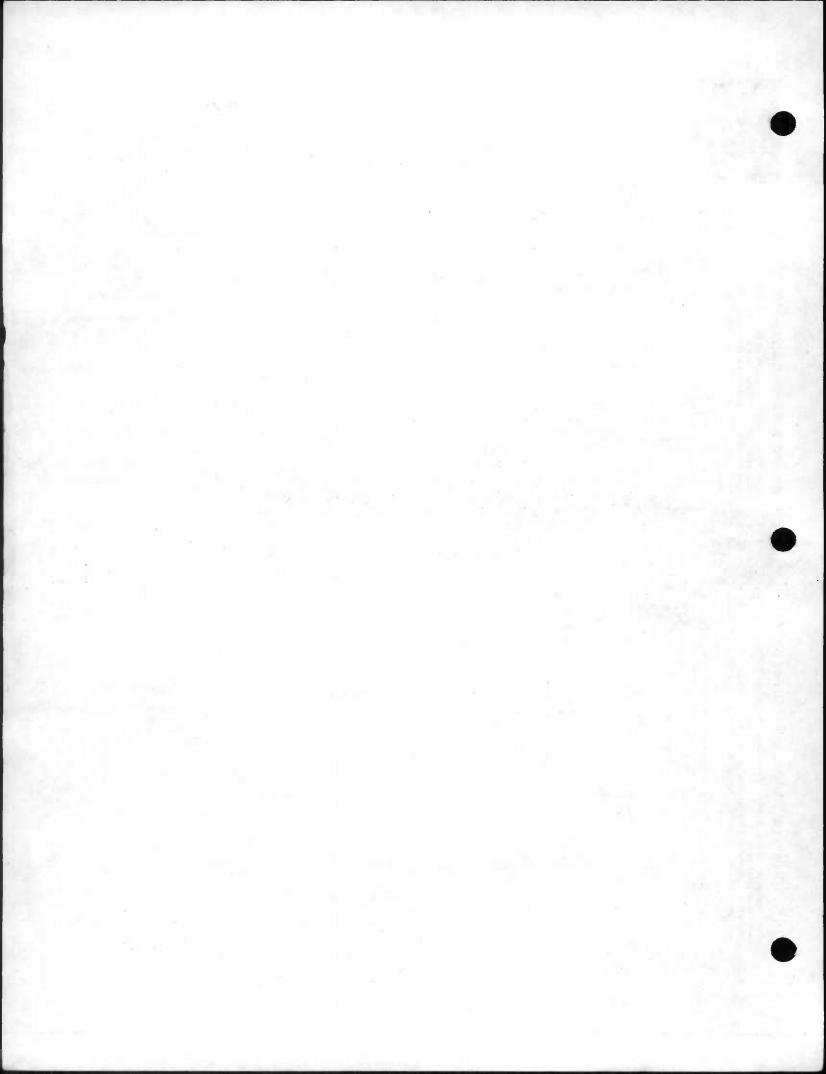
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State of Maryland / Department of Health and Mental Hygiene 9 8 2 7 0 1 7

0.0		3. Time of Death
Month AUS	Day 20	Year 1040 PM
m, or Location of De		
ton		ce Georges.
Min. (Month, Aug.	Birth Day, Year) 24, 1916	9. Birthplace (Stale or Foreign Country) unknown
		10d. Inside City Limits
		1 ☐ Yes 2 ☐ No
	10g. Citizen of 1	What Country?
	U.S.A.	
in? (Specify Yes or Puerto Rican, etc.)	No- 14. Rac	ca - American Indien,
Puerto Hican, etc.)	Specify	ck, White, etc. y: Black
	16b. Kind of B	usiness/industry
of working		
	unknown	1
's Name (First, Mide		
wn		
or Rural Route Nu	mber, City or Town,	Stete, Zip Code)
Date	20c. Location	City or Town, Stete
	1	
		imore Street
land 2120		
ardiac or respirator	y errest,	Approximete Interval Between Onset end Death
		Siladi dina badii
		TWIL
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		1
23b. D	id tobacco use co	intribute to the cause of death?
1	Yes 2 No	3 Probably 4 Unknow
		T an W
	les an autopsy erformed?	24b. Were eutopsy findings available prior to completion of ceuse
_		of death?
1	Yes 2 No	1 ☐ Yes 2 ☐ No
of Death (Check on	ly one)	
sing Home 5□R	esidence 6 🗆 Ott	ner (Specify)
28d. Descrii	be how injury occur	rred
ko		
	n (Street and Numi Town, State)	ber or Rural Route Number,
Ony or	, , , , , , , ,	
place, and due to the occurred at the tin		anner es steted. and due to the cause(s)
	29d. Date signe	ed (Month, Day, Year)
	1. 00 100	(/ 9
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	735.	. 08 22

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State of Maryland / Department of Health and Mental Hygiene

Amended #22	Per F.H. PGC 8-19-98 cr Certificate of Death Rog. No.
Physician	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 1,25
/Medical Examiner	Lamonia 17. LE 190 08-15.98 12-pm 4e Facility Nemse (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Examiner	PRINCE GEORGE HOSPITAL CUTA Cheverly PRINCE GEORGE
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 If Under 1 Year If Under 24 Hrs. Norths Days Hours Min. 8. Date of Birth Day, Year) 9. Birthplace (State or Foreign Country) 1 If M 2 If I Under 1 Year If Under 24 Hrs. Norths Days Hours Min. 9. Birthplace (State or Foreign Country) 1 If I Under 1 Year If Under 24 Hrs. 1 If Under 24 Hrs. 2 If Under 24 Hrs. 3 If Under 24 Hrs. 4 If Under 24 Hrs. 5 If Under 24 Hrs. 6 If Under 24 Hrs.
the Maryland 28=4 show notified at	Usual Residence of Decedent 10e. Stele 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □ Yes 2 No
E S S	10e. Street end Number 10f. Zip Code 10g. Citizen of What Country?
020 urs after death at; or items 23 ammer man by Funeral	11. Merital Stetus 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Merried 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 14. Race - American Indian, Black, White, etc. 15. Was Decedent of Hispanic Origin? (Specify Yes or No-Black, White, etc.) 16. Race - American Indian, Black, White, etc. 17. Yes, specify Cuban, Mexican, Puerto Rican, etc.) 18. Race - American Indian, Black, White, etc.
215-0.	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use petired) 16b. Kind of Business/Industry
d 212 filed withi Hygiene. ther then ent, the M	12 Musewife ITome
ore, Maryland 21. s 1 and 2 should be filed wit wheelth and Mental hygiene flem 27 is marked other tha other traumatic event, the To Be Com	17. Father's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname)
should Me and Me umeric	19e. Intorment's Name/Relationship (Type, Print) / 19b. Mailling Address (Street and Number, or Rural Route Number, City or Town, State, Zip Code)
is 1 and 2 and 2 and 2 litem 27 lis other train	Ruby Boyd 6705 Middle Field Ft. WASH 20144
O 85 = 9	20e. Method of Disposition 20b. Plece of Disposition (Name of Commelor) 20c. Location - City or Town, State
Baltim permit. Pa Departmen Important: any Injury page.	21. Signature of Eurieral Service Licensee 22. Name and Address of Facility Sterling Fun. Serv. 1601 Kenil. Ave. N.E. Wash D.C. 120019
	23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate Interval Between
Physician /Medical	Immediate Ceuse (Final disease or condition Acule Renal Failure lodgys
Examiner	Due to (or es a consequence of): De Hydration 10 days
8760, sate be executed thysician and the burial-transit	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events Due to (or as a consequence of): Due to (or es a consequence of):
Q # 0 8 6	thet initieted events resulting in death) Lest Due to (or es a consequence of): d.
death death of for stellar	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death?
cords, P.O. Box v requires that the death car been signed by the attendin should be detached for usa leted by Physician/N	Old Cerebra vonscular Accident 10 Yes 20 No 30 Probably 40 Unknown
al Records, P.O. Box The law requires that the death cart are has been signed by the attendin page 2 should be detached for usa. Completed by Physician/M	Percipheral Vascular Dislase 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
I Rec	Belalizal Ampirtarian 10 yes 20 No 10 yes 20 No
f Vital Revisions The Land Secretificate he director, page	25. Wes case reterred to medical scaminer? Hospital: Description: Other: Other: Description: De
Division of Vital Records, or Attending Physician: The law requires the after chack. The law requires the after chack. The third this cartificate has been signed in by the funeral director, page 2 should be certification: To Be Completed by	1 Yes 2 No Hospital: 1 D(Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Menner of Death 1 28a. Dete of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred Nursing Home 5 Nur
Division C To the Hospital or Attending P within 24 hours after dath: to the Funeral Director: After completely filled in by the funera Medical Certification:	3 Suicide 4 Homicide 6 Could not be determined 6 Could not be determined 28e. Plece of Injury - At home, tarm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
he Hospiti in 24 houn he Funers pletely fille	29e. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examinar: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.
To the	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 216273 MD 29d. Date signed (Month, Day, Year)
(6)	30 Neme and address of person who completed cause of death (Item 23a) (Type, Print) LEVATHY MVRTHY, 6(80 LANDOUER ROAD, Chaverly
State Registrar	31. Date filed (Month, Day, Year) AUG 1 9 1998 32. Regisfrar's Signature B. Aponth

ANC 1 9 1998 France of Parkers

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-1 ~	12	Certificate			eg. No.	
Phys		1. Decedent's Name (First, Middle, Last) BOLATITO LANAUZE		2. Date of Deet Month		as 3. Time of Deeth
Exan Exan		4e. Fecility Neme (If not institution, give street end number) Wood 3 + C Garden Hursing Home 5. Social Security Number 6. Sex 7. Age (In yrs. liest birthday) If Under 1 Y	ear If Under 24 Hrs.	8. Dete of Birth (Month, Dey,	4c. County of MONTS	
Directo		Usuel Residence of Decedent	eys Hours Min.	Z i	3 50	Nigeria
rith the Maryland or 28a-f show	Director	10a. State 10b. County 10c. City, Town or Location MD Montgomery Silver Spring 10e. Street end Number 10f. Zip Co	de	10	0g. Citizen of Who	10d. Inside City Limits 1 ☐ Yes 2 ☑ No et Country?
and 21215-0020 be filed within 72 hours after death with the Maryland tall hygiene. Indicate than "natural", or items 23a or 28a-f show event, the Medical Examinat must be notified at	by Funeral	11. Marltal Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Specify 1 Yes, Give Yeer or Detes: 1 Yes 2	of Hispenic Origin? (Spe Cuben, Mexicen, Puerto I No Specify:	ocify Yes or No- Rican, etc.)	Black,	American Indien, White, etc. Black
d 21215-0020 filed within 72 hours af Hygiene. ther than "natural", or int, the Medical Exam	Completed	Elementary/Secondery (U-12) College (1-4or 5+)	ecupation one during most of working etired)	ng	Privat	ness/Industry
₩ Salaby	To Be	17. Fether's Name (First, Middle, Lest) Oladosu Sanusi	18. Mother's Name			
2 0 0 0		Pauline Fagbuyi (sister) 3919 Sunflor 20a. Method of Disposition 20b. Place of Disposition (Name of Disposition)	reet end Number or Rure	Mitchel	City or Town, Ste Willey Mc 20c. Location - Cit	1 20721
Baltimore, In permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other the	9169	4 Donation 5 Other (Specify) HArmony Memoria	Park 8	119/98	Landorer	Md
Physicia		23a. Pert Enter the disease, or complications that caused the deeth. Do not enter the mode of shock, or heart failure. List only one cause on dech line.	dying, such es cardiac o	r espiretory erre	est,	Approximete intervel Between Onset end Deeth
/Medica Examine	r r	Immediate Ceuse (Finel disease or condition resulting in death) e. Due to (or es e consequence of):	e_			lyen
68760, ifficete be executed g physician and es the buriel-transit	ai Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury c.				
E 000	n/Medical	thet initiated events resulting in death) Lest Due to (or es e consequence of): d.				
O. B. ne death the etter shed for	Physician/N	Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause	e given in Pert I.	23b. Did tol	bacco uae contri	bute to the cause of death?
requires that the death cer requires that the death cer seen signed by the ettendin hould be deteched for use	by Ph			1 🗆 Ye	2 2 No 3	☐ Probably 4 ☐ Unknow
> W 0	Completed			24e. Wes er perform		24b. Were eutopsy findings eveileble prior to completion of cause of death?
VICAL REPLICATION OF THE PROPERTY OF THE PROPE		25. Wes case referred to medical	20.01 (2.11	1□ Ye		1 Yes 2 No
- S 00	don: To Be	exeminer? 1 Yes 2 No Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA 27. Manner of Deeth 1 Neturel 5 Pending (Month, Dey Year) 28b. Time of Injury (Month, Dey Year) 28b. Time of Injury		ne 5 Reside	nce 6 Other (w injury occurred	(Specify)
To the Hospital or Attending Ph within 24 hours efter death. To the Funeral Director: After thi completely filled in by the funeral	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, ferm, street, fectory, off building, etc. (Specify)		8f. Location (Str. City or Town,	eet end Number (Stete)	or Rural Route Number,
Hospital 24 hours Funeral letely filled	edical	29a. Certifier (Check only one) 1	e time, dete end piece, e ny opinion, deeth occurre	nd due to the ce d et the time, de	use(s) end menne te end place, end	er es steted. I due to the cause(s)
To the comple	Me	29b. Signeture and title or continuer 29c. Lice	cense number	29	ed. Date signed (A	
(3)		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) WARL H. EIG MD 10801 LOCKWOOD DO	2., Siwar	Saruna	MD ?	20901
S Regis	tate trar	31. Date filed (Month, Day, Year) AUG 2 0 1998 32/Registrer's Signeture 6.	21	,	* - : //	

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	1. Decede	nt's Nama (F	irst, Middle, L	ast)								2. Dete of De		Year	3. Tír	me of Deeth
Physician /Medical	Rol	bert	Franc	cis I	Lacey							JULY		998	12:	30P.M.
Examiner	4a Fecility	Name (If no	t institution, g	ve street end nu	ım <i>ber)</i>					4b. City, To	wn, or Loc	cation of Deet	th 4c. Cour	ty of Deeth	1	
	2583	5 FRIE	NDSHIP	SCHOOL	ROAD						VILL:			ARYS		
uneral rector	214-9	Security Numb 98–326	7	Sex 1■M 2□F	7. Age (In y		birthdey) Yrs.	If Undar Months	1 Year Deys		Min.	8. Date of Bi (Month, De December	rth ey, Year) : 16,1981		plece (S untry) ylane	tete or Foreign d
r 28a-f show	Usual Res 10e. Stete	idence of De	b. County		10c.	City, To	wn or Lo	cation							10d, Insi	ide City Limits
D of	Marv	land S'	T. Mar	/'s	l l	Mech	anic	svill	e						1 🗆	Yes 2 No
1 2		and Numbe						10f. Zip					10g. Citizen o	f What Cou	untry?	
	25825	5 Frie	ndship	School	Road			2	065	9			United	d Sta	tes	
y Funeral Director		ever Merried	2 Merried	If Yes, Gi	orces? 2 No ive	n U,S.		Vas Deced Yes, spec				cify Yes or No Rican, etc.)	В	ace - Amer leck, White	e, etc.	en,
d by	3 L W	idowed 4 [Yeer or E	Dates:			C 46- 11								
Completed	Elamani			rade completed)	(1-4or 5+)	16	(Give life. I		k done e ratire	petion during mos ed)	at of workin	ng	16b. Kind of			
event, the Ma		10	at Middle I as	41			Stu	dent		19 Moth	or's Namo	/First Middle	. Maidan Sum	n/a	a	
To Be			st, Middle, Las aniel									nn Qua		erre)		
traum			Reletionship			2	9b. Mailir 5825	g Addrass Frie	(Stree	tend Numb	er or Rura chool	Road,	bar, City or Tou Mechai	m, Stete, Z	ip Code)	20659 MD
Important: If item 27, any injury or other tri	1 ■ B			Removal from	Ctata	ceme	tery, cren	sition (Nemore of the Memore)	ther pla		ens 8	Date 8-4-98	20c. Location			
miner Important: If it is any injury or or once.	22. Name end Address of Facility Brinsfield Funeral 23a. Part I. Enter the disease, or complications had caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Immediate Cause (Final disease or condition rasulting in death) a. Gunshet wound of head															
PhysiciaryMedical Examiner	Due to (or as a consequence of): Sequentially list conditions, if eny, leading to immediate causa. Entar Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or as a consequence of): Due to (or as a consequence of):															
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	Pert II. Oth	ner significar	nt co nditions	contributing to d	leath but not	rasulting	in tha u	nderlying c	ause g	iven in Pert	1.		Yes 28.No		to the co	4 Unknow
page 2 should be c												perf	s en eutopsy formed?	8	availabla completion of death?	opsy findings prior to on of ceuse
tincate tor, pag	25 Was c	ase rafarrad	to medical	1						26 Plan	o of Dooth	(Check only			100	
irec	exami	ner?		Hospital:	Innatient 1		Outpation	t 3 DC	A O	her _			_	ther /Sne	cifu)	
ecfor: After this by the funeral of iffication: T	27. Manner of Death 1 Natural 5 Pending (Month, Dey Young) 2 Accident investigation 3 Suicide 6 Could not be datarmined 4 Methomicida described on the described of the described of the described on the desc					t home,	Time of Injury	2 M	8c. Inju Wo	ury et ork?]Yes 2.⊠	TNo 4	Phome 5 Residence 6 □Other (Specify) 28d. Describe how injury occurred Subject was shot 28f. Location (Street and Number or Rural Route Numb City or Town, State) 25835 Friendship St. Manys County, Manylo				
24 hours after Funeral Dir letely filled in	29a. Certi (Chec	ck only 25		hysician: To the	e best of my l	knowled	ga, death				nd plece, a	ind due to the	a causa(s) and	manner as	stated.	

State Registrar

Strphen S.
31. Date filed (Month, Day, Year)

29b. Signeture end title of certifier

29c. License number

29d. Data signed (Month, Day, Year)

30. Name and address of person who complated causa of death (Itam 23d) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

32. Ragistrar's Signature AUG 03 1998

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State of Maryland / Department of Health and Mental Hygiene

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1 14	- 1	U	V	

Physicia		1. Decedent's Name (First, Middle	, Last)					2. Date of Dee Month		Year	3. Time of Death		
/Medic		James Green Mil	bourne					August	21, 199	98"	10:52 A		
Examin	_	4a. Facility Name (If not institution	, give street and nu	mber)			4b. City, Town, or	Location of Death	4c. County	of Death			
		212 Providence	Road				Elkton		Ceci	1			
uneral irector		5. Social Security Number 197-01-6719	6. Sex 1 M 2 □ F	7. Age (In yrs		Months Days	If Under 24 Hrs Hours Min. A	8. Date of Birth (Month, Pay ugust 16	1 1037	9. Birthple Countr Delaw	ece (State or Forei y) are		
MOI III		Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or L	ocation				10	d. Inside City Limit		
a de de	tor	Maryland Cecil		El	kton						1 ☐ Yes 2 🕱 N		
or 28	Director	10e. Street end Number				10f. Zip Code		1	10g. Citizen of V	Vhat Count	ry?		
230	al	212 Providence	Road			2192	21		United	Stat	es		
than "netural", or lears 23e or 28e-f show the Medical Experient rount be notified at ompleted by Funeral Director	þ	11. Marital Status 1 Never Married 2 Marri 3 Widowed 4 Divorced	Armed Fo	2. ⚠ No ve	J,S. 13	Was Decedent of Hif Yes, specify Cub		Specify Yes or No- to Rican, etc.)	14. Reci Blac Specify	e - America k, White, e Whi	tc.		
Dical	eted	15. Decedent	's Education		16a. Dec	edent's Usual Occup e kind of work done DO NOT use retire	pation during most of wo	rkina	16b. Kind of Bu	ısiness/Indu	ıstry		
the Mo	Completed	Elementary/Secondary (0-12)					d)		Agricu	lture			
event,	Be C	17. Father's Name (First, Middle, I	Last)				18. Mother's Na	me (First, Middle,	Meiden Sumam	е)			
3 0	ToB	Harvey Milbourne						Stel	la Marv	el			
7 is marked traumatic e		19e. Informant's Name/Relationsh	nip (Type, Print)		19b. Mai	ling Address (Street	and Number or R	ural Route Numbe	r, City or Town,	State, Zip (Code)		
any Injury or other tra	Anna Milbourne/	wife		212	Providenc	ce Road,	Elkton,	Marylan	d 219	21			
			☐ Cremation 3 ☐ Removal from State			position (Neme of emetory or other ple	ce) A	ugust 25,	,		ty or Town, State		
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any l		21. Significate of Funeral Service (22. Name end Addre Licks Home .03 West S				arvla	nd 21921					
ical iner	niner	Immediate Cause (Final disease or condition resulting in deeth)	.CAA	Due to	or as e conse		meth		ve		4-6413		
no eur s	edicai	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last	c		or as e conse								
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0	by Physician/M	Tarti. Only algunout continu	ne contributing to d	eath but not re	sulling in the	underlying couse gr	ven in Fait i.		1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unkn				
	Completed							performed? available pr			re autopsy findings llable prior to apletion of ceuse eath?		
rector, page	200							1□ Y	es 2 No	2 → No 1 □ Yes			
director,	Be	25. Was case referred to medical examiner?		26. Place o					Deeth (Check only one)				
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	edical Ce	29a. Certifier (Check only one) 1 Certifying 2 Medical E	xaminer: On the b	asis of examin	owledge, dea ation and/or i	th occurred at the finvestigetion, in my o	me, date end place	e, end due to the curred at the time, d	ause(s) and ma date and place, e	inner as sta	ited. the ceuse(s)		
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pletely fill	Control of	29b. Signature and fitie of certifier	11			29c. Licens	se number		29d. Date signed	d (Month D	lev Veer)		

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 08:47 PM Physician AUGUS? CYNTHIA MADLEY /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CAMP SPRINGS PHINCE GEORGES MALCOMB GROW AFB HOSPITAL # Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | June 13, 1963 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** 1 M 2 TF 35 220-82-6538 Director Washington DC Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits than "natural", or items 23s or 28s-f shorthe Medical Examiner must be notified at the Maryle Maryland Prince George's Landover To Yes 2 □ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2304 Tuemmler Avenue 20785 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 72 hours after 1 Yes 2 XNo
If Yes, Give
Year or Detes: 1 Never Married 2 Married Maryland 21215-0020 **Black** 1 Yes 2 XNo Specify: Specify: à 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry a Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 9th Security Guard Private 17. Father's Name (First, Middle, Last) 18 Mother's Neme (First Middle Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mantal Hy Important: If Item 27 is married oth any Injury or other treumatic event abose. 88 Dean Fitzpatrick Willie Amos 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Donald Fitzpatrick/Brother 2122 Minnesota Avenue S.E., Washington DC 20020 Baltimore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State Curial 2 ☐ Cremetion 3 ☐ Removel from State Forest Hill Cemetery 8/22/98 Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility
J.B. Jenkins Funeral Home 21. Signature of Funeral Service Licenses Charles & Dowmas 7474 Landover Road, Landover, Maryland 20785 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Physician /Medical Immediate Cause (Finel HYPGRTENSIVE ARTERIOSCUEPOTIC CARDIOVASCULAR OSEASE disease or condition resulting in death) Examiner Due to (or es e consequence of) Examine physician and the burlai-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) Box 68760. Cause (Disease or injustrat initiated events resulting in death) Last Physician/Medical Due to (or es e consequence of) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Ounknown þ 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was an eutopsy performed? Completed 1 □ Yes 2 □ No 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: il or Attanding P. aftar death. | Director: After After 1 Netural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Hospital 24 hours a Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the To the To the Complet 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) PME AUGUST 18, 1998 (Itom 23a) (Type, Print) and address of person who completed cause of deat DRIVE, CHEVERLY MARYLAND 2078\$ MARIO 3001 HOSPITAL 31. Date filed (Month, Day, Year) 32. Registrar's Signature

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Registrar

AUG 2 1 1998

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ner	Washington Adventi				akoma Par		Montgo					
	Social Security Number 6. Sex	-	last birthdey	If Under 1 Year	If Undar 24 Hrs.	8. Date of Birth		9. Birthptece (State or Fo				
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	10e. Street and Number	10	het Country?									
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nu.	11. Marital Status 1 ☑ Never Marriad 2 ☐ Married	 Wes Decedant Evar in L Armed Forces? 1 ☐ Yas 2 ☑ No),S. 13.	Wes Decedent of Hi If Yes, specify Cube	n, Mexicen, Puerto	Rican, etc.)		- Amarican Indian, , White, etc.				
by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Yeer or Detes:		1□Yes 2ĂNo	Specify:		Specify:	White				
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OB	Samuel B. Mc	Cutcheon		1000	Unknown							
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	Margaret E. Rath/G	uardian/Attoi	rney 9	9891 Broke	en Land P	kwy Colu	mbia, M	d. 21046				
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DHMH 16 Rav 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician MARY 5:30 AM A. **MOORE** August 15 1998 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Center Prince George's Cheverly If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Deys Hours Months 1□ M 2X F 45 Sept. 16, 1952 Director 243-84-5766 New York, N. Y. Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits -how r than "natural", or flams 23s or 28s-f ehor the Medical Examiner must be notified at 1K Yes 2 No Directo Mary land Prince George's Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 212 Graiden Street 20774 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours effer of Department of Heelth and Mentel Hygiene. Important: if Item 27 Ie marked other than "natural", or Item any Injury or other treumstic event, the Medical Essentence. Black, White, etc. 1 Never Married 2 Married specify: Black Baitimore. Maryland 21215-0020 1 Yes 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 18e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Private Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Albert Douglas Moore Hattie Mae Kinsey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant'a Name/Relationship (Type, Print) Terri S. Moore/Daughter 212 Graiden Street, Upper Marlboro, MD 20774 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 108/20 tX Burial 2 ☐ Cremation 3 ☐ Removel from State Harmony Memorial Park Landover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 1998 21. Signature of Funeral Service Licensee J. B. JENKINS FUNERAL HOME Terco 7474 Landover Road, Landover, Maryland 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Examiner Examine The lew requires that the death certificate be executed physicien end the burlei-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or es a consequence of) Box 68760, Physician/Medical that initieted events resulting in death) Last Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown BONE þ 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Was en autopsy parformed? 2 No 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physicien: within 24 hours effect death.

To the Funeral Director: After this cartification of the funeral director; 8 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of tnjury (Month, Day Year) 27. Manner of Death 28b. Time of tnjury 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturat 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide McCortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) seen w 30. Name and address of person who completed cause of death (Item 23a) (Type Print) P. G. Hospital Center, 20785 ND MD, Dept of Medicine, 3001 Hospital Green, 31. Date filed (Month, Day, Year)

DHMH 16 Rev 6/95

32/Registrar's Signature

AUG 1 8 1998

State Registrar

80 B J 20A

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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State of Maryland / Department of Health and Mental Hygiene

ARGELIO	BARRERA	State of Maryland / Department of	f Health a
	Items: 1,23part	t I,27 per MEO G-768 2/8/99 reCertificate o	of Death

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	Funeral Director		5. Social Security NOT AVAII	LABLE 6. S	ax 7	. Aga (In yrs. 36	lest birthdey) Yrs.	If Unda Months			4 Hrs. Min.	8. Date of Bird (Month, De JULY 3	th y. Yaer) 1962	Coui	place (Stata or Foraigntry) CEMALA	igi
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Maryland 21215-0020	be filed within tel Hygiene. d other than svent, I're Ma	ошріе	Elementery/Seco	ondery (0-12)	Collega (1-4	lor 5+)	(Giva kind of work done during most of working lifa. DO NOT usa retired) LABORER CONST					TRUCT	'ION			
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ary	A DE E	-	19a. Informant's Na	ama/Ralationship (Type, Print)		19b. Maili	ing Addras	s (Stree	at and Number	or Rura	I Routa Numb	er, City or Town	, Stete, Zip	Coda)	
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vision	5 9 9	2	3 ☐ Suicida 4 ☐ Homicida	6 Could not be determined	e 28e. Pleca o	f Injury - At he	ome, farm, st	raat, factor	y, office			28f. Location (ber or Rur	al Routa Number,	

Medical Cer

29a. Cerefie

1 Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and dua to the cause(s) and mannar as stated.

2 Medicaf Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and dua to the ceusa(s) and mannar stated. 29c. Licanse number

29d. Data signed (Month, Day, Year)

O.C.M.E.

AUGUST 31, 1998

Registrar

31. Deta filed (Month, Day, Year) SEP 0 1 1998 111 Penn Street, Baltimore, Maryland 21201

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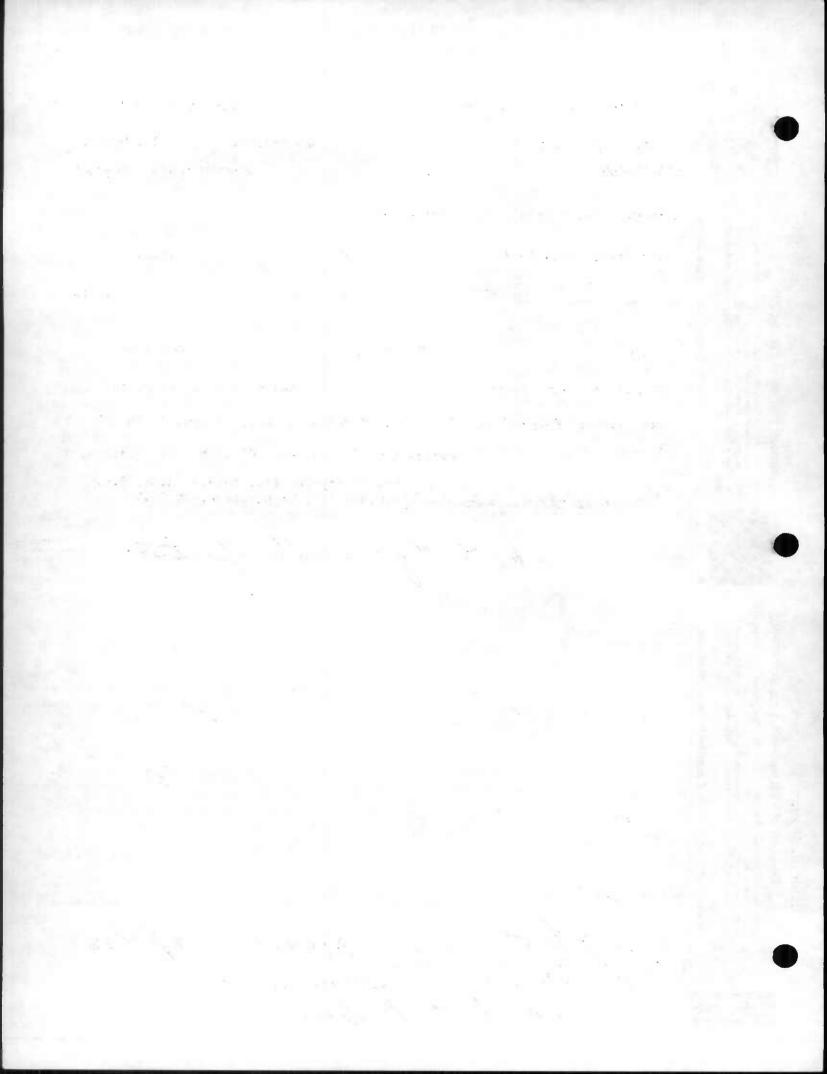
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	Tuesday.		State	of Marylan		rtment of F tificate of		Mental Hy	giene J Reg. No.	6 2	7058
	Physician	1. Decedent's Name (First, Middle						2. Date of De Month	eath Day	Year	3. Time of Deeth
	/Medical	Mabel	Me	yer				August	10, 19	998	7:00 am
	Examiner	4a Facility Name (tf not institution					4b. City, Town, or	Location of Deat	h 4c. County	of Death	
_		Crofton Convale			for a factor of and	If Under 1 Year	Crofton	_	Anne A		
	Funeral Director	5. Social Security Number	6. Sex 1 ☐ M 2 ■ F	7. Age (tn yrs.	Yrs.	Months Days	Hours Mir	. (Month, D			ce (State or Foreign y)
		577–16–7998 Usuel Residence of Decedent		82				April	3,1916	Maryl	and
	yleno how	10a. Stete 10b. County	teal lite	10c. Cit	ty, Town or Loca	ation				100	d. Inside City Limits
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	or 20	10e. Street and Number				10f. Zip Code			10g. Citizen of V	What Countr	y?
	ours after death with the Manyland self, or items 28s or 28s-f show Estantiner maint be notified at by Funeral Director	29994 Point Loo	_			2065			United		
		11. Meritel Status	Armed F		,S. 13. W	as Decedent of I Yes, specify Cub	lispanic Origin? (an, Mexican, Pue	Specify Yes or No rto Rican, etc.)	D- 14. Rac Blac	e - America: ck, White, et	
20	ors after	1 Never Merried 2 Merri 3 Widowed 4 Divorced	ed 1 Tes If Yes, G Yeer or		11	☐ Yes 2■ No	Specify:		Specify	whit	
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212	led within 72 ho ygiene. wr than "natur. rt, the Madical Completed	(Specify only highes Elementary/Secondery (0-12)	grade completed		(Give k	ind of work done O NOT use retire	during most of w	orking			,
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	tal Hygiene. d other than event, me M. Be Comp	17. Father's Neme (First, Middle, I	ast)	75 0.57			18. Mother's Na	ame (First, Middle	, Maiden Sumem	ne)	
yia	should be filed within and Mental Hygiene. marked other than umatic event, the H To Be Comp	Joseph Benjamin	Morgan				Ida Ma	rtha Pil	lsbury		
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Por		20a. Method of Disposition 1 ■ Burial 2 □ Cremetion		State	cemetery, cremi	atory or other pla		Date	20c. Location -		
Baltimore,	it. Pag riment riant: It njury o	4 Donetion 5 Other (Sp		1 OI		oln Ceme	tery	8-13-98	Brentwo	od, Ma	ryland
Ba	pemit. Pages Department of Important: If It eny Injury or phos.	Thus N.	ton V	Jr MOO	0052 229	955 Holl	Br	rinsfield	Funeral	I Home	P.A. 0650-0279
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	Physician			^)			1	Onset end Deeth
	/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	0.7	H5K	mat	ion	neum	romin		, 5	s weeks
		resolving in Gealing	5	Due to (or as e consequ	ence of):	2) 0.	ein D		8	12 years
	n and ral-transit		b	nd	Drug		3 meren	an y	Deare	-	Lyears
Ć.	cate be executed physician and the burial-transit dical Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		Due to (c	w es e consequ	ence or):				1	
8760,	ohysicia the bur dical	thet millered events	с	Due to (o	r es a conseque	ence of):					
မ	Wed the	resulting in death) Last								1	
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0.	law requires that the deeth certific es been signed by the estending p r. 2 should be detached for use as applied by Physician/Merpieted by Physician/Mer	Part II. Other significant condition	ns contributing to o	death but not res	ulting In the und	terlying cause giv	ven in Pert I.	23b. Did	tobacco use co	ntribute to t	he cause of death?
۵.	igned by the observed for the bed etached for by Physic							10	Yes 20 No	3 Probe	ibly 4 Unknown
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Sec	hes t										eath?
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of Vitai	Physician: The law this certificate hes arel director, page 2 or TO Be Comp	25. Was case referred to medical examiner?	Hospitel:			Ott	VOC.	eath (Check only			
	Physic rthis c and dire	1 ☐ Yes 2 ■ No 27. Manner of Death	28a. Dete		ER/Outpatient 28b. Time of	3LI DOA	4 M Nursing	Home 5 ☐ Res 28d. Describe	how injury occur		
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	al or A saftar al Direction by	4 🗆 Homicide	bullo	ling, etc. (Specif	y)			City or To	wn, State)		
	To the Hospital of within 24 hours at To the Funeral Di completely filled in Medical Ces	(Check only 2 Medical E	Physician: To the xaminer: On the t	pasis of examina	wledge, death o	occurred at the tis	me, date end place	e, and due to the	cause(s) and me	enner as ste	led. he cause(s)
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State of Maryland / Department of Health and Mental Hygiene

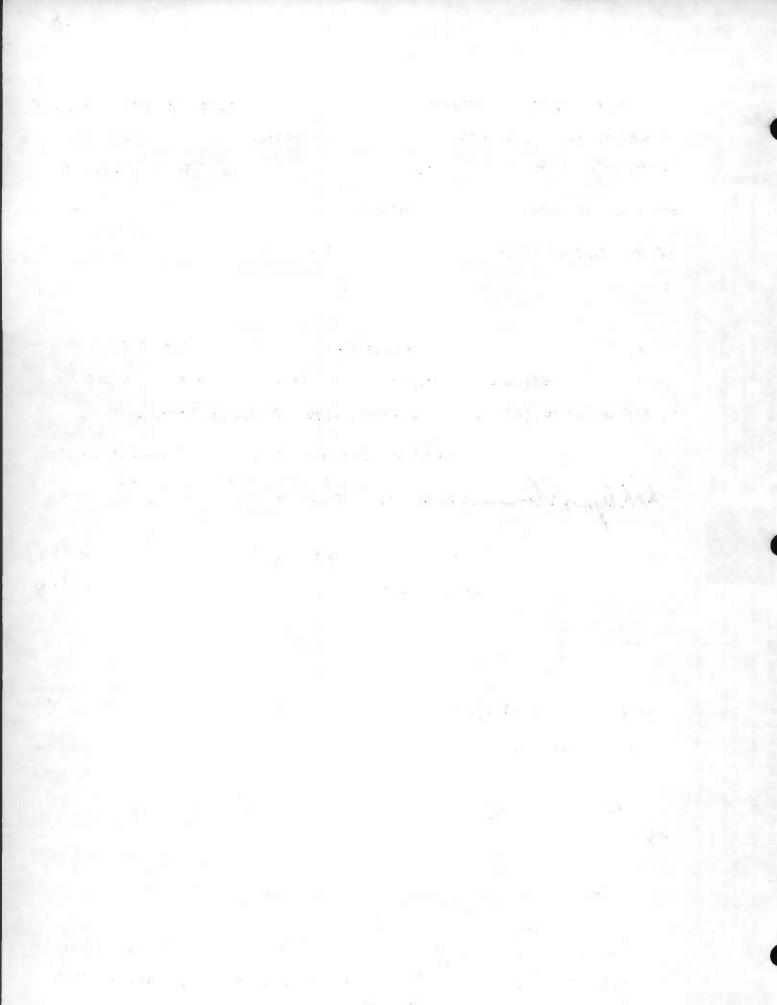
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er	48	Fecility Name (fi	f not Institution	n, give stre	eet and numi	ber)				4b. City, Town, o	r Location	of Death	4c. County	of Death	
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		ocial Security N	umber	6. Sex	2K) F 7		last birthday)	Months	or 1 Year Days	Hours M	s. 8. Da	ate of Birth Ionth, Day, 1 ember 7	(ear)	9. Birthp	place (Stete or F
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		Maryland		Mary	S	п	ollywo								1000
	10e	. Street and Nur	mber					10f. Z	ip Code			10	g. Citizen of	Whet Cour	ntry?
	4	4419 Th	ree Co	ves F	Road				20636				U.S.A		
	11.	Marital Status		12.	Was Daced Armed Ford	lent Ever in U	I,S. 13.	Was Dece	edent of Fecify Cub	lispanic Origin? an, Mexican, Pu	(Specify Yes or No- erto Rican, etc.) 14. Race - American Indien, Black, White, etc.				
	1	1 Never Marri 3 Widowed			1 ☐ Yes 2 If Yes, Give Year or Dat	X No				Specify:			Specif		hite
			15. Decedan	nt's Educat	tion		16a. Deced	dent's Us	ual Occup	ation	16b. Kind of Businass/Industry				
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	-	7 th	nualy (U-12)		Coneda (1-	TOI 0T)	Home	make	r				Own Ho	ome	
		Father's Name ((First, Middle,	Last)						18. Mother's N	ame (Firs	t, Middla, M	aiden Sumar	ne)	
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r other traumati		Thomas Jerrett Jones Annie I 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Re								_			Coda)		
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State of Maryland / Department of Health and Mental Hygiene

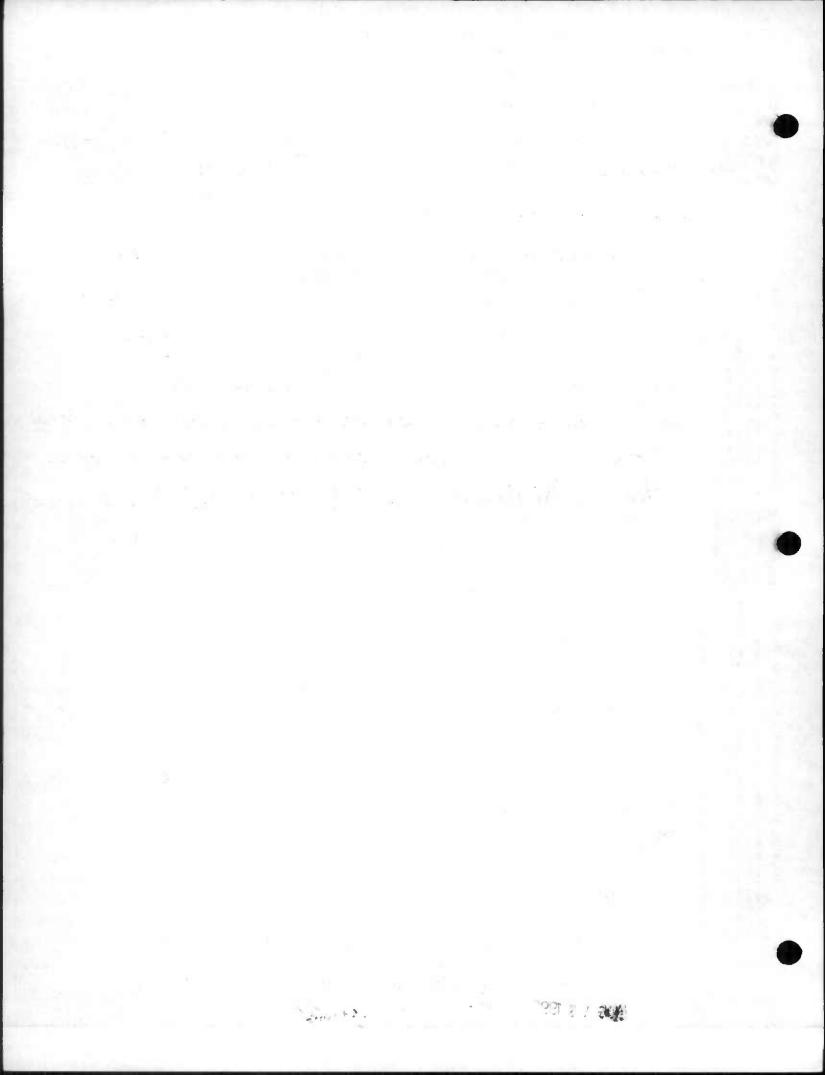
			Certificate of	Death	Reg.	No.			
	1. Decedent's Name (First, Middle, Last)	ETRILLE.			2. Date of Death Month	Day Y	ear 3. Ti	me of Death	
Physician /Medical	PAUL MICHAEL	MOSSBURG				0, 1998		05 AM	
Examiner	4a Facility Name (If not institution, give street and r	num <i>ber)</i>		4b. City, Town, or Local		4c. County of	Deeth		
	Frederick Memorial Ho	spital		Frederic	k		derick		
Funeral Director	5. Social Security Number 213-64-6387 6. Sex 1₺ м 2□ F	7. Age (In yrs. last birthe	Monthe Dave	Hours Min.	Month, Day, Yes	9 957]	Birthplace (S Country) Mary Lar	itate o <i>r Foreig</i> n nd	
p s	Usuel Residence of Decedent 10a. State 10b. County	10c. City, Town o	or Location				10d. ins	Ide City Limits	
Ba-f eho	Maryland Frederick		ederick				10	Yes 2□No	
iffar death with the Ma r thems 23s or 28s-fe from must be notified Funeral Director	360 West Patrick Stree		10f. Zip Code 2170				S.A.		
by	Armed	s 2X No Give	13. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 28 No	dispanic Origin? (Spec an, Mexican, Puerto R Specify:	ify Yes or No- ican, etc.)		American Indi White, etc.	White	
ed within 72 ho ygiena. Nor than "nature it, it a Wederall Completed	15. Decedent's Education (Specify only highest grade complete.	d) 16a. D	ecedent's Usuel Occup	pation duning most of working	rking 16b. Kind of Business/Industry				
than the Mac		(1-40r5+)	Give kind of work done ife. DO NOT use retire		Iron & Steel				
Hygiena. ther than ent, the M	12	ra	ctory Work						
Marked other than marked other than matic event, train To Be Comp	17. Father's Name (First, Middle, Last) Paul William	m Mossb	urg	Fannie	Name (First, Middle, Maiden Surname) Le Doris LACKEY				
or other treumatic event, the Mad	19a. Informant's Name/Relationship (Type, Print) Mr. Paul W. Mossburg/Fa		Mailing Address (Street 6 Key Park						
parmit. Paggs 1 and 2 should pay the payment of Hallh and M important; if item 27 te main any injury or other treumstipines.	20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal fro 4 □ Donetion, 5 □ Other (Specify)	cemetery,	Disposition (Name of crematory or other plate) vet Cemete:			c. Location - Cit			
aw requires that the death certificate be associted with the death of the attending physician and a should be detached for use as the burial-transit before by Physician/Medical Examiner	23a Part Enter the sease, or complications that shock, or heart shure. List only one cause of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intilated events resulting in death) Last Dra Last Dra Last Well W	Due to (or as a co	nsequence of):	hulopat	ederick, respiretory errest	Maryla Nacco use control No 3	Approvince of the completic of death?	ause of death donknow	
						25 No	1 🗆 Yes	2 No	
Be Be	25. Was case referred to medical examiner?		_ 0	26. Place of Death her:					
rhis cartific ral director,	1 Yes 2000	Inpatient 2 ER/Outp	atient 3L DOA	4 Nursing Horr	e 5 Residence Bd. Describe how				
Hing I Aftar funa Ion	Natural 5 ☐ Pending (M	rk?]Yes 2□No	00. D0001100 11011	injury occurred					
To the Hospital or Atlanding Physician 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Pla	ice of Injury - At home, fam Iding, etc. (Specify)			8f. Location (Stre City or Town, S		or Rural Rout	a Number,	
within 24 hours To the Funerell complately filled	29a. Certifier (Check only one) Check only one) Check only one) Certifying Physician: To to the and m						ause(s)		
Me of the	29b. Signature and title of certifier	se number	29d	. Date signed ((Month, Day, Y	'ear)			
- s - ō	· austin Dec		8/2	0 9	ક				
	30. Name end address of person who completed ca		*	a	1 . 1	24 7	1 01 7	701	
	A. Austin Pearre, Jr,		West Ninth	Street, Fr	ederick,	Maryla	and 21	UI	
State	31. Date filed (Month, Day, Year) 32	Registrer's Signature							

DHMH 16 Rav 6/95



State of Maryland / Department of Health and Mental Hygiene 98 2706

				Ce	ertificat	e of	Death		Re	g. No.			
Physi /Me/	ician dical	1. Decedent's Nama (First, Middla, Las.	E M. MED	LE	1			Mo	a of Daath	Day	Yaar	3. Tima	of Death
Exam		4e. Facility Neme (If not Institution, give	1 . (tal				n, or Location of		4c. County Prince	of Deeth	eora	ie's
Funera Directo		5. Social Security Number 6. Sa 424-05-6021		. lest birthday Yrs.	Months	Days			of Birth orth, Day, e 10,	Yaar) 1918		lece (State	a or Foraign
Maryland a-f ahow	stor	Usual Residence of Decedent 10a. Stata 10b. County Maryland Prince Ge		ity, Town or t aure1	ocation						1		City Limits
th with the 23a or 28	al Director	10e. Street and Number 12224 Apache Tea	ars Circle		10f. Zip	Coda 2070)8		10	g. Citizen of \	Whet Coun	try?	
and 21215-0020 be filed within 72 hours after deeth with the Maryland tall thygiena. d other than "natural", or items 23a or 28a-f ahow event, the Modical Examinat must be notified at	by Funeral	11. Marital Stetus 1 Navar Marriad 2 Married 3 Widowad 4 Divorced	12. Wes Decedant Evar in I Armed Forces? 1 ☐ Yas 2 ☒No If Yas, Giva Yaar or Datas:	J,S. 13			lispanic Origir an, Mexican, I Specify:	n? (Specify Ye Puarto Rican, a	s or No- itc.)	Blac	ea - Americ ck, Whita, v: Whi	atc.	
21215-0020 d within 72 hours af giena. rr than *natural*, or than Medical Evant	Completed	15. Decedant's Edu (Spacify only highast grad Elamantary/Secondary (0-12)		(Giv lifa.	edant's Usu a kind of wo DO NOT u	rk dona sa ratire	during most o	of working	1	6b. Kind of Bo Texti Mill		lustry	
Maryland 2121 d 2 should be filed within the end Mental Hygiena. T is marked other than traumetic event, the Mental traumetic event ev	To Be C	17. Fethar's Name (First, Middla, Last) James C. Murph	v				18. Mothar's	s Nama <i>(First,</i>		aidan Suman Peters			
aryla should and Mer	F	19a. informant's Name/Ralationship (T)		19b. Mai	ling Addrass	s (Street		or Rural Route				Coda)	
5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5		Patricia M. Vogt			-		Tears	Circle					0708
		20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Cramation 3 ☐ F 4 ☐ Dorfation 5 ☐ Other (Specify)	Ramoval from Stata	Plece of Disponentary, constants.	amatory or o	othar ple	ce) st Cem.	Data 8/20		oc. Location - amascu	-		nd
Baltimo permit. Pege Department of important: if any injury or		21. Signature of Fundral Sarvica Licens	(.0)		17 / T	37	ss of Facility leswor	th, P.	A., E	uneral Mary	Home	e 208	72-01
Physician	,	23a. Parti. Evier tha disaesa, or composition, or mant failura. List only o	ilcations that caused tha daa na causa on aach lina.	1)				ardiac or raspir	atory arres	st,		Approximintarval Boonset end	ata letween
/ /Medica Examine	_	immediata Cause (Finel diseasa or condition rasulting in daath)	a	Theu	mon	ia.					1.5	5-71	Day,
	ē	, , , , , , , , , , , , , , , , , , , ,	0	or as a cons			Call				1	241	1 -0
axecuted n end al-transit	Examiner	Sequantially list conditions, if any, leading to immediate causa. Entar Underlying Cause (Disaasa or injury	0.	Slava or as a conse	2		Failu	re				241	M2.
I Records, P.O. Box 68760, The law requires that the death certificate be axecuted ate has been signed by the attending physicien end page 2 should be detached for use as the bunal-transit	Medical	Cause (Disaasa or injury that initiated avents rasulting in daath) Last	Due to (or es e corise	quanca of):								
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as thet the da signed by the a	by Physician	Part II. Other aignificant conditions con		sulting in tha	undarlying o	ausa giv	van in Part I.	23		s 2 No	a □ Prot	A	of death? Unknow
VICAL RECORDS, stelen: The law requires the certificate has been signed irector, page 2 should be or	Completed b							24	a. Was an perform		ava	ara autopsy ailable prio mplation of daath?	r to
		05 W							1 □ Yas	//			□ No
ysicial ysicial is certif	o Be	25. Was casa rafarred to medical axaminer?	Hospital: Minpatiant 2] ER/Outpetie	ent 3 DC	Oth	or:	of Death <i>(Chec</i> sing Homa 5			ar (Enacih	4)	
0 5 5 8	Itlon: T	27. Manner of Death Natural 5 Panding 2 Accidant Invastigation	28a. Data of Injury (Month, Day Year)	28b. Tima Injury		8c. Inju		28d. Da		v injury occur		9	-
	Certification:	3 ☐ Suicida 6 ☐ Could not be 4 ☐ Homlcida datarminad	28a. Place of Injury - At h building, atc. (Speci	ioma, farm, s	treet, fectory	y, offica		28f. Loc City	ation (Street or Town,	aat and Numb Stata)	per or Rura	i Routa Nu	ımber,
the Hospital or hin 24 hours afte the Funeral Diru npletely filled in	edical	29a. Cartifiar (Check only one) Cartifying Physical Exami	sician: To the best of my known ar: On the basis of examination and manner stated.	owledga, daa ation and/or i	th occurrad nvastigation	at tha ti	ma, data and poplnion, daath	place, and dua occurred at the	to the cau a time, dat	usa(s) and ma ta and placa,	annar as st and dua to	atad. tha cause	e(s)
To the within To the comple	Me	29b. Signatura and titla at cartifiar SAuil	P MD				a number 4258	0		d. Data signe		Day, Year)	
,		30. Nama and addrass of person who co		m 23a) (Type	, Print)			S am	1 -		*		
S	tate	31 Date filed /Manth Day Vees	32. Registrar's Sign		4.	6-	D.						



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 1998 Gloria Patricia Mathews August 14, 0830 /Medical 4a. Facility Nema (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 13124 Mt. Airy Frederick Manor Drive 8. Data of Birth
(Month, Day, Year)
Jan. 2, 1922 5. Social Sacurity Number If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Massachusetts **Funeral** Days 1 M 200F 053-18-6796 76 Vrs Director Usual Rasidanca of Decedant with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28s-f show any injury or other traumatic event, the Mexical Example Lines the notified at once. Frederick Maryland Mt. Airv 1 ☐ Yes ZZNo Director 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 13124 Manor Drive 21771 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 22000 If Yas, Giva Yaar or Datas: Was Dacadant of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Maxican, Puerto Rican, atc.) 14. Raca - Amarican Indian. Black, Whita, atc. 1 Nevar Married Married Maryland 21215-0020 1 Yas 2X No Specify: Specify: White þ 3 Widowed 4 Divorcad Completed 15. Decedant's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Collega (1-4or 5+) Elementary/Secondary (0-12) Administrator/ Benefits Insurance 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Malden Surname) Be William . 0'Niell Florence Preston 2 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gisele M. Mathews, Daughter 13124 Manor Drive, Mt. Airy, Maryland 21771 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other piece) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Data 1 ☐ Burial 2 In Cramation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Crematory Aug. 20, 1998 Bronx, New York 21. Signature of Funaral Sarvice Licensa 22. Nama and Addrass of Fecility Keeney and Basford PA Funeral Home MO0255 106 East Church St., Frederick, Maryland 21701 23a. Part1. Entar the disaasa, or complications that caused the death. Do not enter the mode of dylng, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onsat and Death Physician /Medical Immediata Ceusa (Final disaasa or condition resulting in death) Disease Coronary Minutes Examiner Dua to (or as a consequanca of): Examiner or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and burial-transi Sequentially list conditions, if any, laading to immadiate causa. Enter Undarlying Causa (Disaasa or injury that initiated avants rasulting in daath) Last and Dua to (or as a consequence of) Box 68760, physician Physician/Medical the Due to (or es e consaguance of) for use Pert II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown **EMPHYSEM** ģ 24b. Wara autopsy findings avelleble prior to completion of cause of death? Completed 24a. Wes an autopsy performed this certificate has 1 ☐ Yas 2 No 1 ☐ Yas 2 ☐ No funeral director, 25. Wes casa raferred to madical axaminer? Be 26. Placa of Daath (Check only one) Hospital: Othar: 4 Nursing Home 52 Rasidance 6 Othar (Specify) Certification: To 1 ☐ Yas 278 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how Injury occurred 5 Panding Invastigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accidant the 6 Could not be detarmined 3 Sulcida 28a. Place of Injury - At home, farm, straat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicida 24 hours a Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiar Medicai To the Hosp within 24 hor To the Fune completely fi (Check only one) 29b. Signatura and titla of certifiar 29d. Data signed (Month, Day, Year) 29c, Licensa number August 14, 1998 me MO WO 05160 30. Name and addrass of person who complated causa of death (Itam 23a) (Type, Print) Frederick, MD 31. Data filad (Mooth Day, Year) 1000 204 Swite Auc 32. Rag strar's Signatura State Registrar

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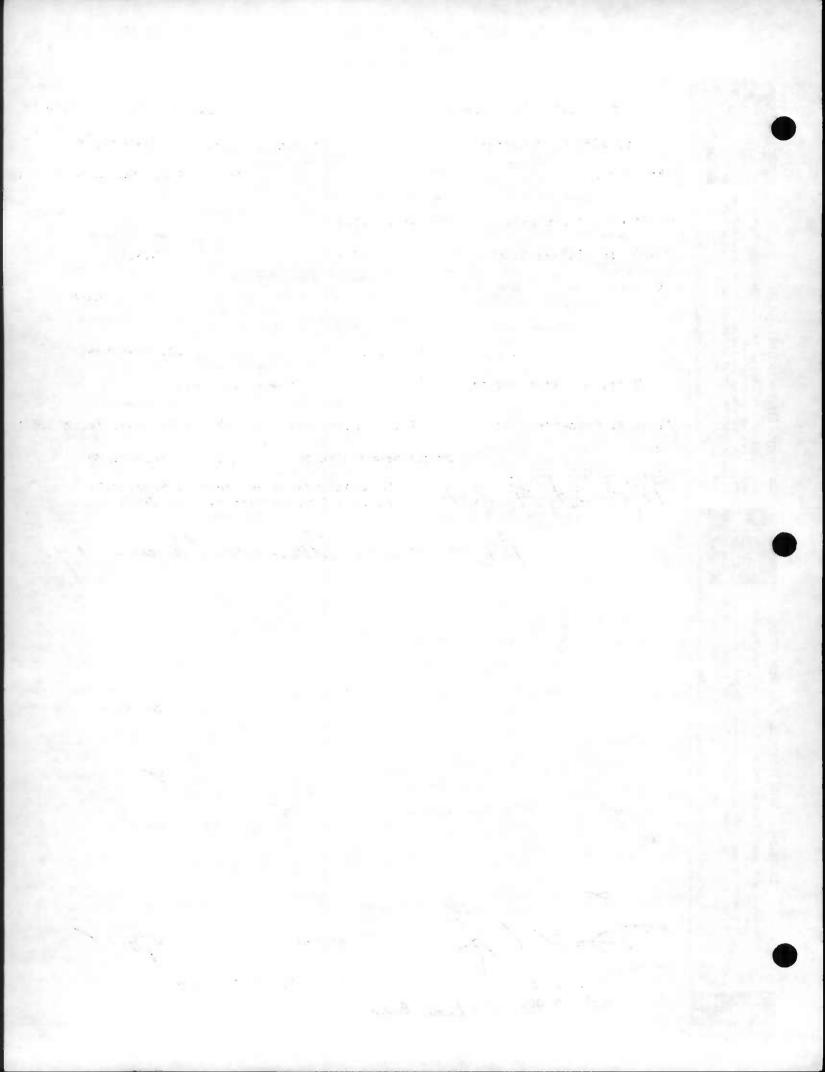
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middle Last) 2. Data of Death **Physician** Month 0055 Helen Mildred Nowland Augus7 /Medical 4e. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Elkton Cecil Union Hospital of Cecil County | If Under 1 Year | If Under 24 Hrs. | 8. Deta of Birth (Month, Day, Yaar) | Necember 1, 6. Sax 5. Social Sacurity Number 7. Age (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** 1 M 28 F 216-46-6348 94 Yrs. 1903 **Director** Maryland Usuel Rasidance of Dacedant with the Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at Maryland Cecil Elkton 1 ☐ Yas 2 N No Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? ŏ 4671 Telegraph Road 21921 items 23a United States Funeral 12. Wes Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yes 2 ☐ YNo If Yas, Giva Yeer or Datas: 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Ricen, atc.) 14. Race - Amarican Indian, Black, Whita, atc. filed within 72 hours efter 1 ☐ Naver Married 2 ☐ Married ŏ Specify: White 1 ☐ Yas 2 XNo Specify: by 3 Widowed 4 □ Divorced "naturel", Completed Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Dacedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. nnt: If Item 27 is marked other than ' ury or other traumatic event, it a Me Elemantary/Secondary (0-12) Coliaga (1-4or 5+) Homemaker 10 Baltimore, Maryland 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be Gustavus Henderson Gertrude Scotten Lo 19a. Informant's Name/Ralationship (Typa, Print) 19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) M. Lorraine Nowland/daughter 4671 Telegraph Road, Elkton, Maryland 21921 20b. Placa of Disposition (Nama of cametery, cramatory or other place) 20a. Method of Disposition Deta 20c. Location - City or Town, Steta 1 ☑ Buriai 2 ☐ Cramation 3 ☐ Ramoval from Stata August permit. Page Depertment of Important: If any injury or once. Sharps Cemetery Fair Hill, Maryland 4 ☐ Donation 5 ☐ Othar (Spacify) 21,1998 21. Signetura of Funeral Sarvica Licensaa 22. Nama and Addrass of Facility Hicks Home for Funerals, P.A. 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Interval Betwaan Onsat and Death **Physician** Sufarction /Medical Immediata Causa (Final Hours. disaasa or condition rasulting in daath) Examiner Dua to (or es a consequança of): Examiner The lew requires that the death certificate be executed Sequantially list conditions, if any, laading to immadiata causa. Enter Underlying Causa (Disease or injury that initiated events rasulting in deeth) Last pue Dua to (or es e consaguance of): P.O. Box 68760. ettending physician for use as the buria Physician/Medical Dua to (or as e consequance of) been signed by the e should be detached t Part II. Other algorificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records. þ 24b. Wara autopsy findings aveilebla prior to Completed 24e. Was an autopsy performed? complation of ceusa this certificate has 1 ☐ Yas 2 ☐ No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 4 hours after death. Funeral Director: After this certifica funeral director, 25. Was cesa rafarrad to medical Be 26. Placa of Daath (Check only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Othar: 4 Nursing Homa 5 Residence 6 Othar (Spacify) 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manger of Death 28d. Dascribe how injury occurred 28b. Tima of 5 Pending investigation 1 Natural 1 ☐ Yas 2 ☐ No 2 Accidant in by the 6 Could not be datarminad 3 Sulcide 28a. Ptace of Injury - At homa, farm, streat, factory, office building, etc. (Spacify) 28f. Location (Streat and Number or Rural Routa Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled Medical 1 Certifying Phyelcien: To the bast of my knowledge, death occurred at the time, date end piece, end due to the ceusa(s) end mannar es stated.

| Medicat Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, end due to the ceuse(s) and mannar stated. 29e. Cartifier 29b. Signatura and title of certifiar 29d. Data signed (Month, Day, Year) 29c. License number Jachder 3 30. Name end eddrass of person who complated causa of death (Item 23a) (Type, Print) 31. Data filed (Month, Day, Year) 32. Ragistrar's Signatura State Registrar B. Sparks

DHMH 16 Rev 6/95

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Maryland	2 sho and is m	19a. Informent's Name/I	Relationship (Ty	rpe, Print)		19b. Maili	ng Addres	s (Street	en <i>d N</i> um <i>be</i>	r or Rura	l Route Numb	er, City or Town,	State, Zip	Code)
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ore	Pages 1	20e. Method of Disposition 1 X Burial 2 □ Cra		amoval from		Place of Dispo cemetery, cre-	metory or	me or other plea	a)	i	Date	20c. Location -	City or To	wn, Stete
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Division of	tal or Attending P rs efter death. al Director: After t led in by the funer Certification:	3 ☐ Suicide 6 [4 ☐ Homicide	Could not be determined	28e. Place building	of Injury - At h	ome, farm, st	reet, facto	y, offica		2	8f. Location (Street end Numb wn, State)	er or Rura	al Route Number,
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	To the Hospital or Attending Physician: The law within 24 hours effer death. To the Funeral Director: Affer this certificata has completely filled in by the funeral director, paga 2 Medical Certification: To Be Comb	29a. Certifier 1		nar: On the ba	asis of examina							ceuse(s) end me date end place, o		
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Part II. Other signif	icant condition	one contributing to	death bu	t not resuit	ing In tha	underlying ca	use giv	en in Pert I.				to the cause of d	
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2 ☐ Accident 3 ☐ Suicide	6 Could	not be	ce of Iniv	Inv - At hom	e form of	treat, fectory,			28f Location	(Street and I	Vumber or 9	ural Route Number,	
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State Registrar

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be deteched for use as the burlat-transit completely filled in by the funeral director, page 2 should be deteched for use as the burlat-transit

Division of Vital Records, P.O. Box 68760,

Physician /Medical **Examiner**

Funeral Director

permit. Peges 1 and 2 should be filed within 72 hours efter death with the Marylend Department of Health and Mentel Hyglene.
Important: If lean 27 is marked other than "netural", or items 23s or 28s-f show any injury or other traumatic event, the Hedical Exprince mass be notified as

Physician /Medical Examiner

Baltimore, Maryland 21215-0020

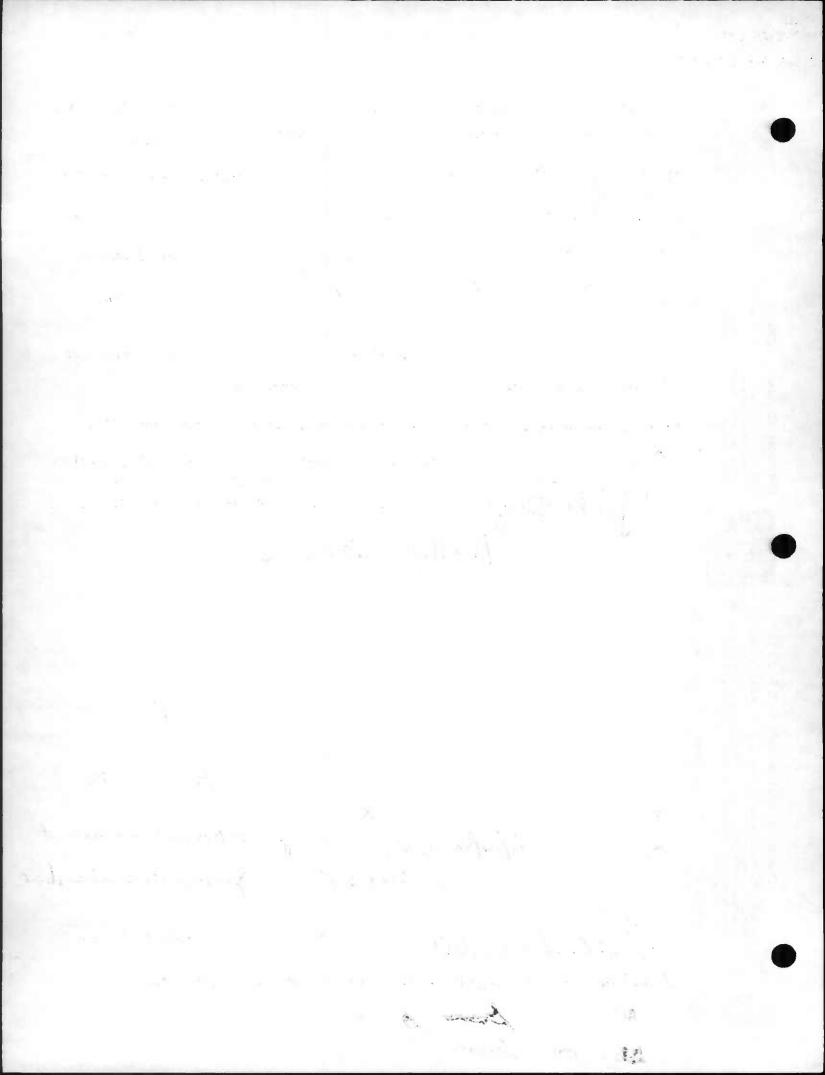
To Be Completed by Funeral Director



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ADH	Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
98-4768-021	Please Type of Print in black indelible link. Assure All Copies Are Legible.
DOUBLI DENITAMENT OCUP	State of Maryland / Department of Health and Mental Hygiene 98 27066
BRYAN BENJAMIN OGLE	Certificate of Death

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lical	BRY.			NJAMIN		OGLE		AUGUST		998	0301 AM	
iner	4e Facility Neme (4b. City, Town, o	or Location of Deat	th 4c. Count	y of Deeth		
	FREDERIC					day) If Under 1 Ye				lericl		
	5. Social Security N		6. Sex		(In yrs. lest birth	Months Day		in. (Month, D			plece (Stete or Foreigntry)	
	216-82-6 Usual Residence of				33 "			Sept.3	1964	Penn	sylvania	
	10a. State	10b. County	y		10c. City, Town	or Location				1	0d. Inside City Limits	
ı	Maryland	Fred	erick		Fred	lerick					1 Yes 2 □ No	
	10e. Street and Nu	mber		-		10f. Zip Code	9		10g. Citizen of	Whet Cour	ntry?	
	241 Wy	ngate 1	Drive			217	01		United	Stat	es	
	11. Marilel Status		12. Wes	Decedent E	ever in U,S.	13. Was Decedent of If Yes, specify C	of Hispanic Origin?	(Specify Yes or N	0- 14. Ra	ce - Americ		
ı	1 Never Marr		rried 1 🗆	Yes 2 N	0	1 □ Yes 2 🗷 N				ν: Wh:		
	3 Widowed			or Dales:								
-	(Spe	15. Deceder cify only highe	nt's Education est grede comple	eted)	16a. D	ecedent's Usuel Oc Give kind of work do ife. DO NOT use ret	cupation ne during most of v	vorking	16b. Kind of 8	3usiness/In	dustry	
	Elementary/Seco	ondary (0-12)	Colle	ege (1-4or 5	+)				Lingto N	100000		
	17. Father's Name	(First, Middle	. Last)		1	ruck Driv		Waste Management ame (First, Middle, Maiden Sumeme)				
	Robert			gle			Jenn	v S. La	ne (First, Middle, Maiden Sumeme) S. Late			
	19a. Informent's N				19b. F	Mailing Address (Str		,		n, Stete, Ziu	Code)	
	Shannon					Wyngate						
	20e. Method of Dis	position			20b. Placa of D	Disposition (Neme of cremetory or other		Date	20c. Location			
	1 Burial 2 4 □ Donation		3 ☐ Removal	from Slale		ld U.M. C		8-20-98	Garfiel	ld. Ma	rvland	
	21. Signature of Fi						dress of Facility S					
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-	23e Perti Enter	the disease of	or complications	tha caused	the deeth. Do no	1621 Opos	sumtown	Pike/ Fre	ederick, armest	Md.	21702 Approximate	
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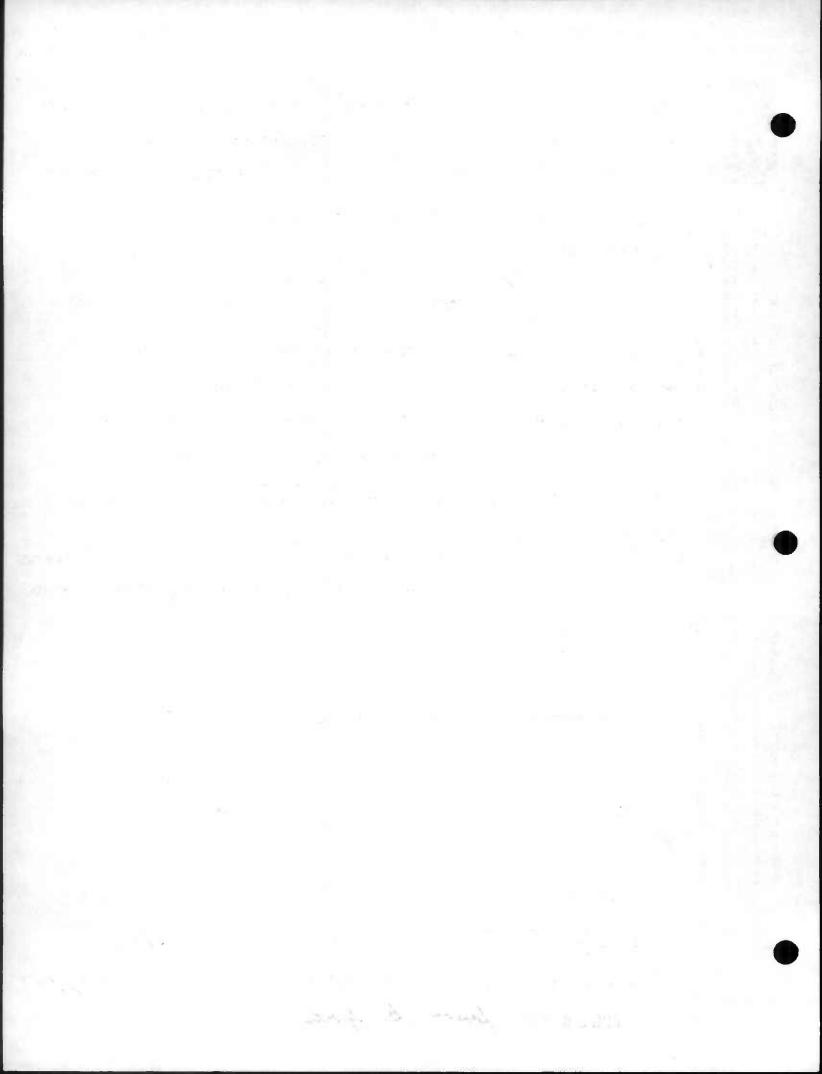
State of Maryland / Department of Health and Mental Hygiene 98 27067

				Certifica	te of	Death		Reg. No.				
Physician	1. Decedent's Name (First, Middle, Las MARY L	OFFUT	T				2. Dete of D	eeth Dey	Yaer 1998	3. Time of Deeth 8:47 An		
/Medical Examiner	4a Facility Neme (If not institution, give		ITAL C	ENTER		RAND	ALLS TO WA		y of Deeth	HURE		
Funeral Director	5. Social Sacurity Number 6. Social Sacurity Number 214-48-6294 Usuel Residence of Decedent	7. Aga □ M 2□ ¼	(In yrs. lest birti	finday) If Unda Months	Deys	If Under 24 Hours	Min. (Month, D	irth Pay, Year) 18 1911	Count	leca (Stete or Foreign try)		
e Marylend	MD Baltimo	ore	10c. City, Town Randal		n				10	0d. Inside City Limits 1 Yes 2 No		
ufer deeth with the Ma r frems 23s or 28s-fs incer must be notified Funeral Director	10e. Street end Number 8 Willow Brook	Court		2		-1527		10g. Citizen of U.S.	Α.			
elf, o	11. Merital Status 1 □ Navar Married 2 □ Married 3 □ Widowed 4 □ Divorced	12, Was Decedent E Armed Forcas? 1 ☐ Yes 2 ☒ N If Yes, Give Year or Datas:		13. Wes Dec If Yes, sp		lispanic Origin en, Mexican, F Specify:	7 (Specify Yes or N Puarto Rican, etc.)	Bla	ca - America ack, Whita, e fy: Whi	etc.		
C	15. Decedant's Ed (Specify only highest grant Elementery/Secondery (0-12)		+)	Decedent's Us (Give kind of w life. DO NOT Postal	ork done use retire	during most of ker			osta	lustry l Service		
2 should be filed within end Mantal Hygiana. 8 marked other than sumatic event, I'm M To Be Comp								le, Meiden Sume 15	ne)			
and 2 sho selth end 1 n 27 is me er trsume	19a. Informant's Name/Reletionship (7) Lucille Walther		er 8	Willo	w Br	ook C	or Rurel Routa Num ourt, Ra			21111		
Department of Her mportant: If item any Injury or othe ange.	20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			Disposition (No.), cremetory or lary s	ome of other ple	ce)	8/18	20c. Location Barnes				
permit. Pag Department Important: I any Injury o	21. Signature of Funerel Service Lican 21. Signature of Funerel Service Lican 22. Pert1. Enter the disease, or compshock, or heart failure. List only	. ,		Hi	lton	ss of Fecility Fune	ral Home	938				
certificate be axecuted and reding physicien end use as the buriel-transit are an armony medical Examiner	Immediate Ceuse (Final disease or condition resulting in death) Sequentially list conditions, if eny, leading to immediate cause. Enter Undertying Cause (Disease or Injury that initiated avents resulting in death) Lest	b	Due to (or as a c	consequenca of):	10/450	ivida 1	013 E456	(1)			
the death y the attain iched for inysicial	Pert II. Other significant conditions co	ontributing to death bu	t not resulting in	the underlying	cause giv	ven in Pert I.		d tobacco use c	ontribute to	o the cause of death?		
							24e. We	es en eutopsy formed?	ava cor	ere eutopsy findings allable prior to mpletion of cause deeth?		
ysician: Tha lew is certificate has t director, page 2 s To Be Compli	25. Wes case referred to medical					00 Pl	1 Deeth (Check only	Yes 2 No	10	Yes 2 No		
2 00	exeminer? 1 Yes 2 No 27. Manner of Deeth 12. Naturel 5 Pending 2 Accident investigation	Hospitel: 1 ☐ Inpatie		tpetient 3 time of njury	28c. Inju Wo	ner: 4 🗆 Nurs	ing Home 5 ☐ Re 28d. Describ					
Pari i										ber or Rural Routa Number,		
within 24 hours within 24 hours to the Funeral completely filled										the cause(s)		
To the company of the	29b. Signature and title of certifiar	Roth	m			y 91		AUGUS	ed (Month,	Day, Year)		
	30. Name and address of person who of 5401 OLD COV		eeth (Item 23e) (Type, Print)	TOWN	, MAP	zyutno	2113	3			
State	31. Dete filed (Month, Day, Year)	32. Registr	r's Signeture	B.	Ana	alla)						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

					Ce	rtifica	te of	Death		Reg. No.			
Dhara		1. Decedent's Nama (First, Middla,	Last)				100		2. Data of Da	ath	Vens	3. Tima	of Death
Phys /Me	ician dical	John	Doegel		Po:	iske	r		August	17, 199	Yaar 98	8:25	PM
Exam		4a. Facility Nama (If not institution,	give straat and number)					4b. City, Town, or	Location of Death	4c. County	of Death		
		27735 Oriole Ro	ad					Princess		Some	rset		
Funer Directo		177-20-3440	7. Ag	e (In yrs. la:	st birthday) Yrs.	Month:	ar 1 Yaa Days				9. Birthpl Count Penns	try)	e o <i>r Foraign</i> nnia
pue 🕺		Usual Rasidance of Dacedent 10a. Stata 10b. County		10c. City.	Town or Lo	ocation					10	ld Insida	City Limits
Menyl f sho	ō	Maryland Somer	set		rince		nne						as 20 No
the 28a	Director	10e. Street end Number	300		11100		ip Coda			10g. Citizen of	What Count		
Baltimore, Maryland Z1Z15-U0Z0 semit. Pages 1 end 2 should be filed within 72 hours after death with the Menylend separtment of Health and Mental Hygiene. mportant: If item 27 is marked other then "natural", or items 23s or 28s-f show my injury or other traumatic event, its Medical Examine must be notified at ance.	erai Di	27735 Oriole Roa					21853			USA			
	by Funeral	11. Marital Status 1 Nevar Marriad 2 Married 3 Widowad 4 Divorced	12. Was Dacedant Armad Forces? 1 ☐ Yas 2 ☐ If Yes, Giva Yaar or Dates:				/	Hispanic Origin? (Span, Mexican, Pual	Spacify Yas or No rto Rican, atc.)	Specify	ea - Amarica ck, Whita, a		
72 ho	eted	15. Dacedant's (Specify only highast)	Education		18a. Dece	dent's Us	ual Occu	pation	orkina	16b. Kind of B	usinass/Ind	ustry	
within ene.	Completed	Elamantary/Secondary (0-12)	Collega (1-4or !					during most of wo	Technic				
e filed w al Hygier other th	S	12	4		MECHA	NICA	L_EN	GINEER					-
be fill H and out	Be	17. Fethar's Nama (First, Middla, La	,						ma (First, Middla,	Maidan Suman	na)		
should be and marked of umarked of	2	Anthony Poisker							Cincus				
d 2 sho h and 7 is me traum		19a. Informant's Name/Relationship									ne, Md. 21853		
ges 1 end 2 should be filed within to filed within to filed within to filed within and Mental Hygiene. If item 27 is marked other than or other traumatic event, I and		Marjorie Poiske	:\MTI6	20b. Pla	ce of Dispo			nuau, ri	Data	20c. Location			
permit. Pages 1 end 2 Department of Health a important: If item 27 is any injury or other tra		1 ☐ Burial 2 ☐ Cremetion 3 4 ☐ Donation 5 ☐ Othar (Spa		can	natary, crai isbur	matory or	othar pl		8/18/98	Salisbu			
omit.	ouce	21. Signature of Funaral Sarvice Lic 23a. Part / Enter tha disaasa, or or 100 ft., or heert failure. List on			22	2. Name	and Addr	ass of Facility					
antificate be executed as the buriel-transit est the buriel-transit	Medical Examiner	rasulting in daath) Saquantially list conditions, if any, laading to immediate causa. Enter Underlying Cause (Diseasa or Injury that initieted avants rasulting in daath) Last	b	Due to (or a				DCTIVE	Purmonx	ary Di	SEASE	- X	FARE
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e de the e	Physician/	Part II. Other eignificant conditions	contributing to death b	ut not rasulti	ing In tha u	ındarlying	ceusa g	ivan in Part I.	23b. Dld 1	obacco uaa co	ntribute to	the caus	e of death'
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aw requii	Completed b						performed? eveileble		ileble prio	ion of causa			
The ate h	Con								101	res 200 No	1 🗆	Yes 2	□ No
vician: The certificate rector, pag	Be	25. Was casa refarred to madicel examinar?							ath (Chack only o	ne)			
Physic this o	2	1 ☐ Yes 200 No	Hospital: 1 ☐ Inpatia		R/Outpatier		M	har: 4□ Nursing I		dance 8 □Oth)	
Attending Physician: The law in death. ector: After this certificate hes by the funerel director, page 2 s	ation:	27. Manner of Deeth 1 Natural 5 Panding 2 Accidant invastigat	28a. Date of Inju (Month, Da)	y Year) 2	28b. Time of injury M 28c. Injury et Work? 1 ☐ Yas 2 ☐ No				28d. Dascribe how injury occurred				
To the Hospital or Attending Physician: The I within 24 hours effer death. To the Funeral Director: Affer this certificate he compiletely filled in by the funeral director, page	Certification:	3 ☐ Suicida 4 ☐ Homlcida 6 ☐ Could not ba detarmined 28a. Place of Injury - At homa, farm, street, factory, offica building, atc. (Spacify)						City or Tox				mber,	
To the Hospital or within 24 hours efter To the Funeral Director completely filled in b.	edical	29a. Certifiar (Check only one) Cartifying I	Physician: To the bast of aminar: On the basis of and mannar sta	examination	adga, daath n and/or in	h occurre vestigatio	d at tha t n, in my	ima, date end place opinion, daath occ	e, and dua to the urred at tha tima,	o the ceuse(s) and mannar as statad. ima, date and place, and dua to tha ceusa(s)			a(s)
or the	Σ	29b. Signature and title of cortifier	/	-		2	9c. Lican				d (Month, E	Day, Year)
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		30. Neme and address of person wh		eath (Itam 2	3e) (Type,					•	,		
		RONALD	P. TRAU	172	MI	>	56 C	RIVER	SIDE	DR SA	LISE	URY	MD
S • Pegis	tate	RONALD 31. Date filed (Month, Day, Yaar)	1,0.0	ar's Signatur	_	>	56C	RIVER	SIDE	DR, SA	21	URY	-

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath 3. Tima of Death **Physician** Month Dorothy A. Phillips August 1998 8:05 AM /Medical 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner 424 Old Conowingo Rd. Conowingo Cecil 5. Social Sacurity Number If Undar 1 Yaar If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) **Funeral** Birthpiace (Stata or Foreign Country) 1 □ M 2 💢 F Days Months 400-38-6768 68 Yrs. Director June 1930 Kentucky Usual Residence of Dacedant the Maryland 10a Stata 10b. County 10c. City, Town or Location a or 28a-f show be notified at 10d. Inside City Limits Director 1 Yes 2 No Maryland Cecil Conowingo 10e. Street and Numbar 10f. Zip Coda 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours eftar death with ment of Health and Mental Hygiana.

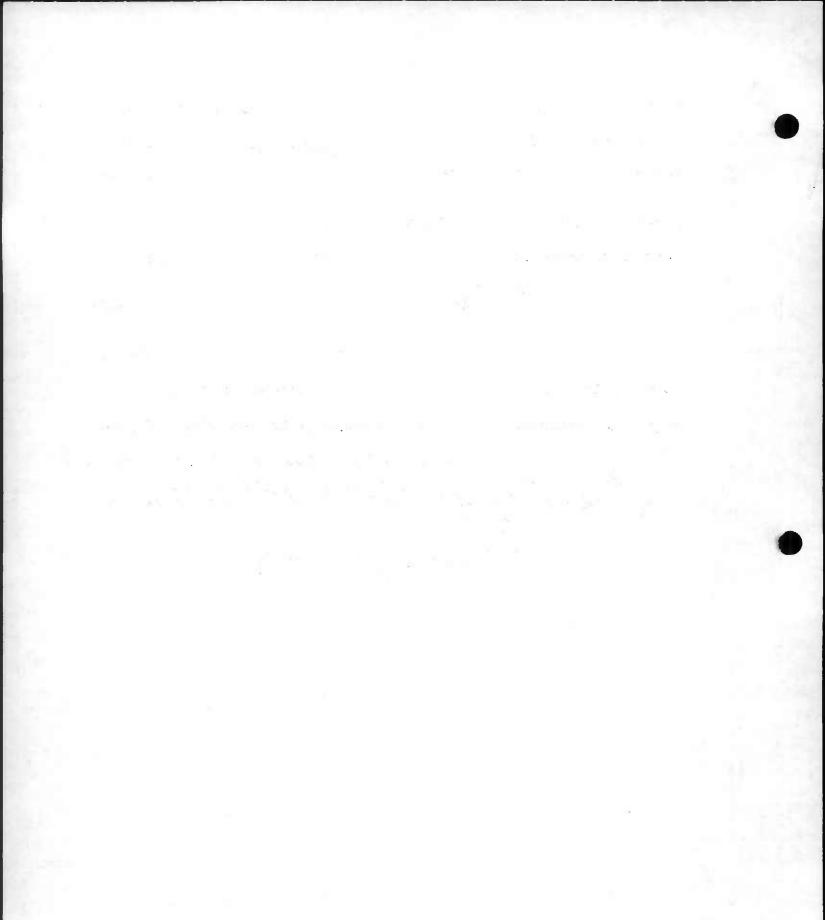
If it it is rarked other than "natural; or items 23s or usy or other traumatic event, the Medical Exprise mental by 424 Old Conowingo Rd. 21918 Funeral USA 12. Was Dacadant Evar in U,S. Armad Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Maxicen, Puerto Ricen, atc.) Race - American Indian, Black, Whita, atc. 14. Race -1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: 1 ☐ Naver Merried 2 X Married 21215-0020 1 Yas 2 No Spacify. Completed by Specify: 3 Widowed 4 Divorced White 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Dacedent's Education 16b. Kind of Businass/Industry (Specify only highast grade complated) Elemantary/Secondary (0-12) Collega (1-4or 5+) Homemaker Own Home Baltimore, Maryland 17. Father's Nama (First, Middla, Last) 18. Mothar's Name (First, Middla, Maidan Surnama) Be Arthur L. Lockhart Lillie Baumcardner 19a. Informent's Name/Ralationship (Type, Print) 19b. Meiling Addrass (Streat and Number or Rural Routa Number, City or Town, State, Zip Coda) Ralph Phillips/Husband 424 Old Conowingo Rd. Conowingo, MD 21918
Data 20c. Location - City or Town, Stata 20b. Place of Disposition (Nama of camatery, crametory or other place) 20a. Mathod of Disposition 1 Burial 2 □ Cremation 3 □ Ramovel from Stata 4 □ Donation 5 □ Other (Spacify) permit. Page Depertment important: if any injury or West Nottingham Cemetery 8-27-98 Colora, Maryland 21. Signature of Fun ral Sarvice Licansee R. T. Foard Funeral Home, P. A. 111 S. Queen St. Rising Sun, Rising Sun, MD 21911 23a Part that the disease, or complications the Laused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, which, or heart failure. List only one cause in each line. Approximata Intarval Between Onset end Daath Physician /Medical Immediata Cause (Final NU N disaase or condition rasulting in daath) **Examiner** (or as e consaquence of): Examiner The law requires that the death certificate be executed the bunai-transit Sequantially list conditions, if any, laading to immadiata ceusa. Entar Undarlying Causa (Disaase or Injury that initieted avants rasulting in daath) Last Bud Dua to (or as e consequence of) P.O. Box 68760, Physician/Medical Dua to (or as a consaquance of) for use as Part II. Other significant conditions contributing to death but not rasulting in the undarlying causa given in Part I. 23b. Did tobecco use contribute to the cause of deeth? É Yes 2 No 3 Probably 4 Unknown Records, 9 þ 24b. Wara autopsy findings eveilabla prior to page 2 should Completed 24a. Was an autopsy performed? complation of causa of daath? 1 Yes 2 No 1 ☐ Yas 2 ☐ No of Vital or Attanding Physician: director, Be 25. Was cese rafarrad to medical 26. Placa of Death (Check only ona) Othar: 4 ☐ Nursing Homa 5 Residance 6 ☐ Othar (Specify) 2 1 ☐ Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA this filled in by the funeral 27. Manner of Daath Certification: Data of Injury (Month, Dey Yeer) 28b. Tima of After 28c. Injury at Work? 28d. Dascribe how injury occurred Division 5 Panding invastigation 1 Neturel deeth. 1 ☐ Yas 2 ☐ No 2 Accidant within 24 hours after deet To the Funeral Director: 3 Sulcide 6 Could not be datarmined 28f. Location (Straat and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At homa, farm, street, fectory, office building, etc. (Spacify) 4 | Homicida Hospital 1 Certifying Phyalcien: To the best of my knowledge, death occurred et the tima, date and plece, and due to the ceuse(s) end manner as steted.

| Medical Examinar: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, data end place, end due to the ceuse(s) end manner stated. 29a. Certifian Medicai (Check only one) the 29b. Satura and titla of certifian 29c. Licensa number 29d. Dete signed (Month, Day, Year) 115 Shune dille Rd Daplington md 21034 0700

State Registrar

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/Medical Examiner physicien end the buriel-transit Box 68760 certificate be 80 USB 0 P.O. the deteched signed by t Records, been page 2 certificate Division of Vital or Attending Physician: director, this

Physician

Physician

/Medical

Director

Funeral

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Completed

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7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at

permit. Peges 1 and 2 should be filed within 72 hours after deeth v
Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "natural", or items 29a and injury or other traumatic event, tra Medical Exercises 200.

Baltimore, Maryland 21215-0020

Examiner Physician/Medical by Completed Be 2 Certification:

edical

27. Manner ot Death

Hospital of 24 hours e Funeral D To the Within 2

efter death.

30. Name and address ot person who complated cause ot death (Itam 23a) (Type, Print) State

1 Natural

3 Suicide

29a. Cartifian

2 Accident

4 ☐ Homicide

(Check only one)

31. Date tiled (Month, Day, Year) AUG 1 9 1998

29b. Signature and title of certifier

5 Pending

Investigation 6 Could not be



28a. Date of Injury (Month, Dev Year)



28b. Time of

28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28d. Describe how Injury occurred

28t. Location (Street and Number or Rurel Route Number, City or Town, State)

1 🗹 Certifying Phyaician: To tha bast of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

7500-HANOVER PARKWAY, GREENBELT, MD. BERTRAM WEISBAUM, P.A.

28c. Injury at Work?

1 Yes 2 No

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Registrar

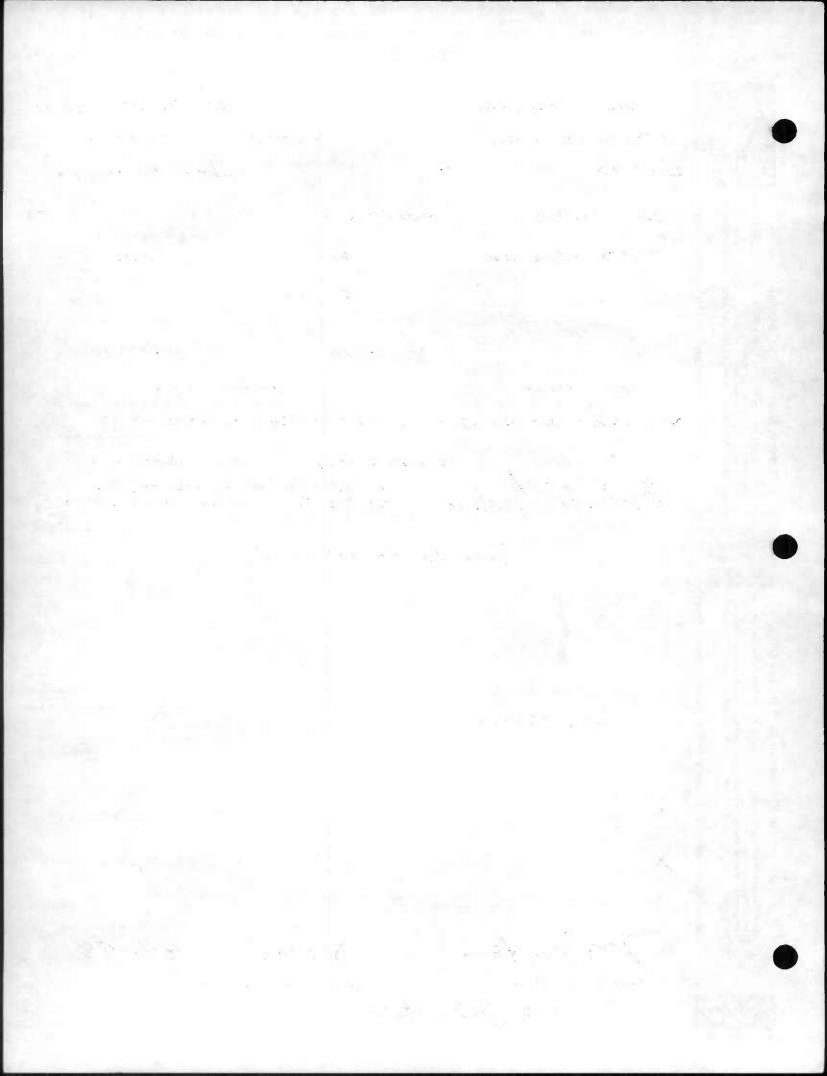
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State of Maryland / Department of Health and Mental Hygiene

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			Cei	rtificate of	Death		Reg. I	No.		
	1. Decedent's Name (First, Middle, L	ast)	127.				of Death	Dev V	3. Time of	Deeth
Physician /Medical	Charles Finch facker					August 4, 1998			9:40	AM
Examiner	4a Facility Name (If not institution, g 28953 Three No					vn, or Location on icsvill	ocation of Death 4c. County of Death St. Mary's			
Funeral Director		Sex 7. Age (In yrs 1 1		If Under 1 Year Months Days	If Under 2 Hours	Min. (Moi	of Birth oth, Dey, Ye ober 11	, 1937	Birthplace (State of Country) Virginia	r Foreign
Pu &	Usuel Residence of Decedent 10a. State 10b. County	100.0	ity, Town or Lo	ocation					10d. Inside Cit	ty Limits
the Maryler 28a-f show northed rector	Maryland St. Ma			icsville					1 □ Yes	
E P P	10e. Street and Number 28953 Three No	otch Road		10f. Zip Code 20659			10g.	Citizen of Wh		
020 urs after aff. or its	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in the Armed Forces? 1 ☐ Yes 2 ☒ No if Yes, Give Yeer or Detes:		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 No		gin? (Specify Yea , Puerto Rican, e	s or No- etc.)		American Indian, White, etc.	
5-0 72 ho	15. Decedent's I		16a. Deced	dent's Usual Occu kind of work done	pation	of working	16b	. Kind of Busi	ness/Industry	
1 2 1 2 1 3 -0 ed within 72 ho ygjene. For then 'nature in, the Medical in, the Medical Completed	Elementery/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	id)		17-	od Com II	holesale	
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Maryland S nd 2 should be filled the and Mentel Hyg 27 is merked other traumatic event, To Be C	17. Fether's Name (First, Middle, Las Finch Par				aurene	Hov				
farylan 2 should be and Mentel is marked o sumetic eve To Be	19a. Informant's Name/Relationship		19b Mailir	ng Address (Stree	1		-		tete. Zip Code)	
Ma id 2 s id 2 s ith an ith an ith an ith an	Deborah Ann Hatc			2nd Str						
Baltimore, M parmit. Pages 1 end 2 Depertment of Health Important: If Item 27 is any Injury or other tra page.	20e. Method of Disposition 1 □ Burial 2 ▼Cremation 3 4 □ Donation 5 □ Other (Spec	20b.	Place of Dispo cemetery, cres	osition (Neme of metory or other ple	ce)	Date 8/6/9	20c	Location - C	ity or Town, State	
Itin	21. Signat0re of Funeral Service Lice			n Cremator	<i>y</i>		8 A	lexandr:	ia, VA	
Balt parmit. Depertrimportu Importu any Inju	mul De	2/2	M	lattingle	y-Gar	diner Fu				
	23a Part 1 Enter the disease or ch	malications that caused the dea	th Do not ent	P.O. Box	270,	Leonard t	own,	Maryla	nd 20650 Approximat	A
Dhuaisian	23a. Part1. Enter the disease, or co shock or heart failure. List onl	y one cause on each line.	in. Do not on	ior the mode of dy	ing, odon oo	out dies of foops	,		Intervel Bet Onset end I	ween
Physician /Medical	Immediate Cause (Final	· Suicie	, ,	10,0	11	1				
Examiner	disease or condition resulting In death)				lxe.	se.				
į de la		Due to (or as a consec	quence or):						
cate be axecuted physician and s the bunet-trensit	Sequentially list conditions	Due to (or as e consec	guence of):						
axec an an inel-tr	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that leithed excess)									
filicate be ay physician as the buriel	that initiated events Due to (or as a consequence of):							1		
BOX 508 auth certifica attending ph for use as ti										
S, P.O. BOX as that the death ce gned by the attendi be datached for use by Physician/	Part II. Other significent conditions	contributing to death but not re	sulting in the u	inderlying cause of	iven in Part f	23	h. Did tobac	cco use conti	ribute to the cause	of death
P.O. at the de dby the attached Physic	\ \	e e e e e e e e e e e e e e e e e e e	saming in into a	indonying dedde gi	VOTE IN CARE I		1 Yas	11	Probably 4	
S, F as that igned to be dath by P	Depl	lession						/		
require been si should			Wh			24	a. Wes en a performed	utopsy j?	24b. Were autopsy to available prior to completion of co of death?	indings o ause
The lav							1 🗆 Yes	2X) No	1 □ Yes 2 □	No
VITAL III III III III III III III III III I	25. Wes case referred to medical				26. Place	of Death (Chec				
Of VITa Physician: this certific and director,	examiner? 1 2 Yes 2 No	Hospitel:	ER/Outpatier	nt 3 DOA		rsing Home 5		e 6 Other	(Specify)	
g Phys er this neral di	27. Manner of Death	28e. Date of Injury (Month, Dey Year)	28b. Time o	28c. Inju		-		injury occurred		
DIVISION C bell or Attanding P rs effer death. el Director: After t led in by the funers Certification:	1 □ Naturel 5 □ Pending investigati	on	injury		Yes 2	No				
DIVISION OF Attendent effer death Director: d in by the	3 Suicide 6 Could not determine		nome, ferm, str	reet, fectory, office		28f. Loc	cation (Stree y or Town, S	t end Number	or Rural Route Num	iber,
Sed in Cert										
To the Hospital or Attant within 24 hours effar deat To the Euroral Director: completely filled in by tha Medical Certifical		hysicien: To the best of my kn miner: On the basis of examin and menner stated.								5)
within 2 To the comple	29b. Signature and title of certifier	1		29c, Licen	se number		29d.	Dete signed	(Month, Day, Year)	
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	30. Name and address of person why William Boyd,	convoleted ceuse of deeth (Ite	m 23e) (Type,		rdtow	n, Maryl		0	, 9	
			ature		LULOWI	i, maryl	and			
State Registrar	31. Date filed (Month Day Year) AUG 1 0	1998 32. Registrar's Sign	dia Ran	lall						

DHMH 16 Rev 6/95



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State of Maryland / Department	of Health and	Mental Hygiene

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Physician						Month	Dey	Year		
/Medical	Georgia Horner Pe				4b. City, Town, or L	Augu			3:55 P.M.	
Examiner										
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Funeral Director		TM 2DE	65 Yrs	Months Dev	Hours Min.	8. Date of Birt (Month, De September		Penns	ece (Stete or Foreign ly) Sylvania	
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23a or 28a-fahow int be notified at al Director	Maryland St. Mar	v's	Califor	nia					1 ☐ Yes 2 ■ No	
r 28a	10e. Street end Number	<i>y</i> 3	Callion	10f. Zip Code			10g. Citizen of V	Whet Count	try?	
234 0	24069 North Patux	ent Beach	Road	20619			United	State	es	
or items indestina	11. Meritei Stetus 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Wes Decadent Ev Armed Forces? 1 ☐ Yes 2 ■ No If Yes, Give Yeer or Dates:		3. Was Decadent of If Yes, specify Cu 1 ☐ Yes 2 ■ No	Hispenic Origin? (Speen, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	- 14. Rec Bled Specify	e - America k, Whita, e		
"natural", ideal Eus leted by	15. Decadent's Ed	ucation	16e. De	cedent's Usuel Occi	petion					
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C FE	12 17. Fether's Name (First, Middle, Last)		Nui	sing Assi		o /Firet Middle	Health Care Middla, Maidan Surneme)			
or other traumatic event, I	Herbert G. Lewis				Marie			,		
traumatic event, To Be C	19e. Informent's Name/Relationship (7	ima Panti	405 44	nilino Address /Ct-s	at and Alumbar or Pu	ml Roudo Numbe	er City or Town	State 7in	Code)	
trau	James W. Penningt		240	69 North	Patuxent	Beach Ro	oad. Cal	iforr	nia, MD	
other	20e. Method of Disposition		20b. Plece of Di	sposition (Neme of		Date	20c. Location -	City or To	20619 wn, State	
	1 Buriel 2 Cremation 3 4 Donatory 5 Other (Specify		cemetery, o	cremetory or other p		20 00				
Injury 8.	21. Signature of Juneral Service Licen		Metropol	itan Crem		-28-98	Alexandi	ria, v	Virginia	
Important: any injury once.	Mary B. Rizzo	M01114		Brinsfiel 22955 Hol	d Funeral lywood Roa	ad, Leor	nardtown	, MD	20650	
	23a. Pert1. Error the cliseese, or comp shock, or hear failure. List only	nications thet caused the	ne daath. Do not	anter the mode of d	ring, such es cerdiac	or respiretory e	rrast,		Approximete Intervel Between Onset end Deeth	
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s the buriel-transit	Sequentially list conditions, if eny, leeding to immediate cause. Entar Underlying Ceuse (Diseasa or injury that infliated events	c	ue to (or es e con							
	resulting in deeth) Lest									
d for	Pert II. Other significant conditions co	ontributing to deeth but	not resulting in th	e underlying cause (ivan In Part I	23h Did	tobacco use co	ntribute to	the cause of death?	
hys	onto agrinoun conditions of	g to doctil but		- sinconying bareat (y		Yes 25 No	3 □ Prot		
be dateched in by Physic										
should						24a. Was perfo	an autopsy prmed?	ava co/	ere eutopsy findings ailabla prior to mpietion of cause daath?	
I director, paga 2 To Be Comp						1/2	Yes 2□No	1/2	√as 2□No	
tor, p	25. Wes case referred to medical				26. Place of Dee	th (Check only o	one)			
al director, To Be	exe <i>m</i> iner? 1 🛣 Yes 2 🔲 No	Hospital: 1 Inpatian	XXER/Outpe	tient 3 DOA	thor	ome 5 Resi		er (Specif)	y)	
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completely filled in by the funeral Medical Certification:	3 Suicide 6 Could not be datermined	28e. Place of Injur building, atc.	y - At home, farm (Spacify)	street, fectory, offic		28f. Location (City or To	Street end Numi	G & W	in Route Number	
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dica	29e. Certifiar (Check only one) 1□ Certifying Phy 2√ Medicai Exam	vsician: To the best of iner: On the besis of e and menner state	xaminetion end/o	aath occurred at tha r investigation, in my	tima, deta and piece opinion, daath occu	, end due to tha rred et the time,	causa(s) and m data and place,	annar as st and dua to	teted. tha causa(s)	
Me Mo	29b. Signeture end title of certifier	. 4		29c. Lice	nse nu <i>m</i> ber		29d. Date signe	d (Month,	Dey, Year)	
) (h(Chart.		0.	C.M.E.		August	26. 1	1998	
	30. Neme end eddress of person and of	complated causa of dea	ath (Itam 23a) (Ty	pe, Print)		n-1::				
0	Dennis J. Chu 31. Dete filed (Month, Day, Year)	TE MP 32. Registrer	's Signature	III Penn	Street, 1	Baltimoi	re, Mary	Land	21201	
State Registrar	AUG 2 8 19			. Span	61					

Registrar DHMH 16 Rev 6/95

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Baltimore, Maryland

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parmit. Page Department of Important: If any Injury or once.

Physician /Medical

Examiner

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After

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within 24 hours e To the Funeral C completely filled Hospital

filled In by

The law requires that the death certificate be executed

P.O. Box 68760,

Records,

of Vital

Division

or Attending Physician:

To the

Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year Helen Madeline Quade AUG. 1998 /Medical 4:17pm 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CIVISTA MEDICAL CENTER If Under 1 Yeer | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | March 5, 1918 Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) 1□M 2\ F 579-09-6368 80 Yrs. Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits 1 ☐ Yes 2 No Director St. Mary's Mechanicsville Maryland 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 31399 Point Lookout Road 20659 U.S.A. Completed by Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black. White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: 3 ☑ Widowed 4 ☐ Divorced White Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Own Home 12th Homemaker 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George C. Buckler Carrie Buckler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 8170 Plowden Drive, LaPlata, MD 20646 Susan M. Gray/Daughter 20b. Place of Disposition (Name of cometery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 8/6/98 4 ☐ Donation 5 ☐ Other (Specify) St. Joseph's Cemetery Morganza, Maryland 21. Signature of Funeral Service Licensee 22. Name end Address of Facility
Mattingley-Gardiner Funeral Home, P.A. 23e. Part1. Enter the disease, or complications that caused the death. Disconter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List grily one cause on each line. P.O. Box 270, Leonardtown, Maryland 20650 Approximate tnterval Betw Immediate Cause (Final disease or condition resulting in death) FEW DAYO Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as e consequence of): Part il. Other significant conditiona contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? ATHERO SCLEROSIS 1 Yes 2 No 3 Probably 4 Unknown by RENAL FAILURE 24b. Were autopsy findings eveileble prior to completion of cause of death? Be Completed 24a. Was en eutopsy performed? FAILURE LIVER 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medicat exeminer? 26. Plece of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Menner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. fnjury at Work? 28d. Describe how Injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 4 \ Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, end due to the cause(s) and menner as steted.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature end title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 8-2-98 D-26064 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rt. 5 & GOLDEN BEACH RD PO BOX 282 VIDYASAGAR ANMANGANDLA

State Registrar

31. Date filed (Month, Day, Year) AUG 04 1998 32. Registrar's Signature Adia Dhuidean Rardall CHARLOTTE HALL, MD 20622

DHMH 16 Rev 6/95

Physician	1. Decedent's Neme (First, Middle, L	.ast)			of L		2. Dete of Dec			Time of Death		
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/Medical Examiner	ELLEN GERARD 4e Fecility Neme (If not institution, g		III		4	b. City, Town, or L	August ocation of Deeth			45 P.M.		
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Funeral Director	150-50-9638	Sex 7. Age	(In yrs. lest birti	hday) If Under 1 Months	Deys	Hours Min.	8. Date of Birtl (Month, De) NOV • 26	(, Year)	9. Birthplece Country) New Yo	(Stete or Foreign		
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23a or 28a-i show ust be notified at rai Director	Maryland Harfo	rd	Be	l Air					1	Yes 2□No		
be notified Director	10e. Street and Number			10f. Zip C	Code			10g. Citizen of V	Vhet Country?			
al le	202 Idlewild Roa	d, Apt 2-C	2:	21014			USA					
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itamir,	Edward Andrew Murphy 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete,									le)		
27 ls r trat	Mary Ellen Whitt - Mother 607 Teaberry Rd., Edgewood, MD 21040											
othe other	20e. Method of Disposition 20b. Place of Disposition (Neme of Dete 20c. Location - City or Town, Stete											
TY OF #	1 Burial 2 M Cremation 3 Removed from State 4 Donetion, 5 Other (Specify) Hilltop Service Corp. 9/4/98 Towson, Maryland											
Department of Health and Mantel Hygiena. Important: If item 27 is marked other than eny injury or other traumatic event, the Maganes. To Be Complete.	21. Sin nature of Funeral Service La 23a. Planti. Enter the disease, of co- shock, or heart feilure. List onl	Man	the death. Do n	1317 C	K.	McComas sbury Rd.	, Abing	don, MD	21009 App			
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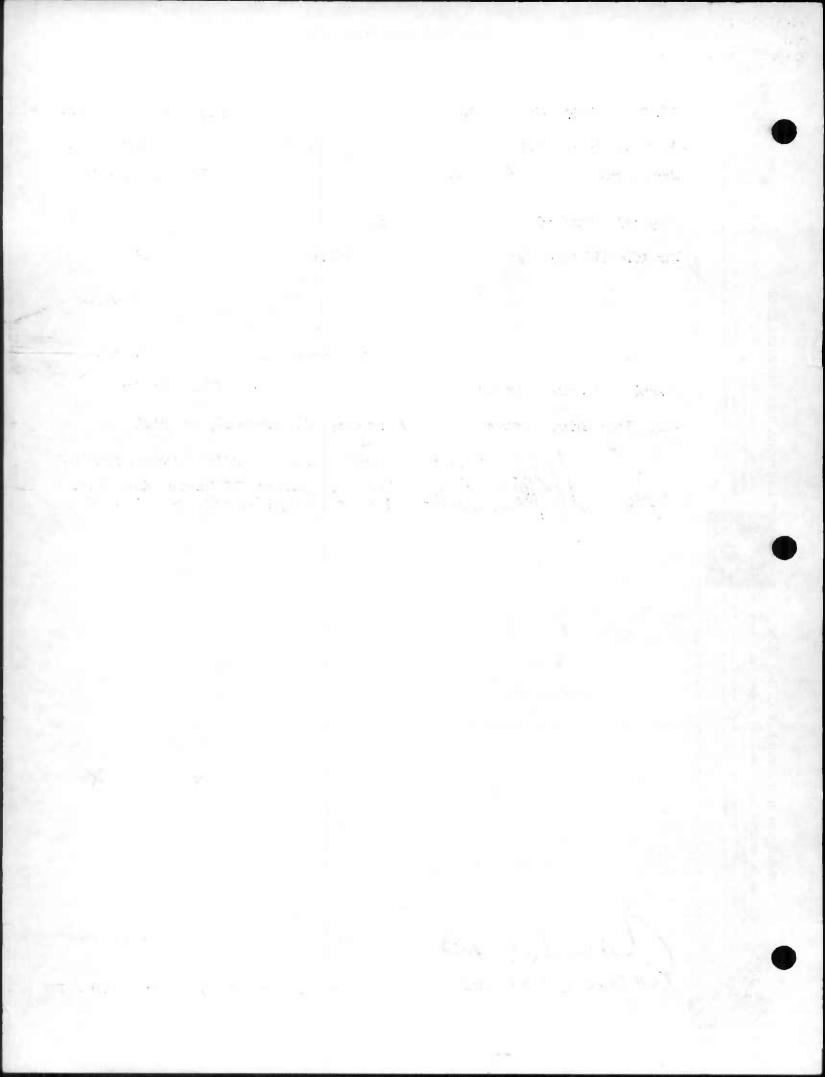
who completed cause of deeth (Item 23e) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201 31. Dete filed (Month, Dey (Year) 1998

State Registrar

O.C.M.E.

August 31, 1998



OBERT F. ROLAND State of Maryland / Department of Health and Mental Hygiene Certificate of Death ITEMS: #23 PART I, 27, 28A-F PER MEO G763 9-8-98 WR. 1. Decedent's Neme (First, Middle, Lest) 2. Date of Death 3. Time of Death Month Day Year **Physician** 1933 PM FRANCIS ROLAND JR. ROBERT **AUGUST** 19, 1998 /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 430 CRYSTAL BEACH ROAD CECILTON CECII. Hours Min. 8. Date of Birth (Month, Day, Year)

Jan 11 1976 If Under 1 Year 5. Social Security Number 6. Sex ★ M 2□ F Birthpiace (State or Foreign Country) 7. Age (In yrs. lest birthdey) Funeral Months Days 219-90-1983 22 Maryland Director Usual Residence of Deceden the Maryland 10c. City. Town or Location x 28a-f show 10a. State 10b. County 10d. Inside City Limits MD Cecil Cecilton 1 ☐ Yes 2X No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with "natural", or items 23a or 430 Crystal Beach Rd. 21913 U.S.A. filed within 72 hours after death Hygiena. Funeral 12. Wes Decedent Ever in U.S.

Armed Forces?

1 12 Yes 2 10 No 1 955 11 Yes, Give 1 2 3 Ctive Wes Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 Never Merried 2 Married Specify: White 1 Yes 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced the Medical Completed 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grede completed) United States Elementery/Secondery (0-12) College (1-4or 5+) Senior Airman Air Force 12 7 is marked other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) . Pagas 1 and 2 should be fill mant of Haalth and Mantal Hant: If item 27 is marked oth lury or other traumatic even Be Robert Francis Roland Sr. Kathleen Annand 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Palmer (mother) P.O. Box 9 Cecilton, MD. 21913 20b. Place of Disposition (Neme of cemetery, cremetory or other of 20a. Method of Disposition 20c. Location - City or Town, State 8/25/98 etery, cremetory or other place) 12 Burial 2 ☐ Cremation 3 ☐ Removel from State permit. Page Department of Important: If any injury or St. Stephen's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Earleville, MD. 21. Signature of Funeral Service Ligenses 22. Name end Address of Fecility Galena Funeral Home of Stephen Schaech M00510 Box 235 Galena, MD. 21635 23 Part Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final MULTIPLE INJURIES disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner physician and the burial-transit that the death cartificate be executed Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical Due to (or as e consequenca of): attanding pl signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Were autopsy findings available prior to completion of cause of death? been si Completed 24a. Was an autopsy performed? s cartificate has b 1X Yes 2□ No 2 No Division of Vital or Attending Physician: director 25. Was cese referred to medical Be 26. Plece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1XX es 2 No this funaral 28d. Describe how injury occurred SUBJECT DRIVER OF 28e. Date of Injury (Month, Dey Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? P After 5 Pending investigation Injury 1 Natural DREASTER , RAFLEASER THROTERE AND after death. 1 Yes 2 No 8-19-98 7:30 2 X Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 430 CRYSTAL BEACH ROAD CECILTON, CECIL CO., MD 28e. Place of Injury - At home, ferm, street, factory, offica building, etc. (Specify) HOME (DRIVEWAY) filled in by 4 Homicide 24 hours 8 Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the Hosp within 24 ho To the Fune complately f Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) O.C.M.E. AUGUST 20, 1998 30. Name and address of person who completed Juse of death (Item 23e) (Type, Print) 0 111 Penn Street, Baltimore, Maryland 21201 THE DONE MIKING 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

State Registrar

AUG 2 5 1998

32. Registrar's Signature

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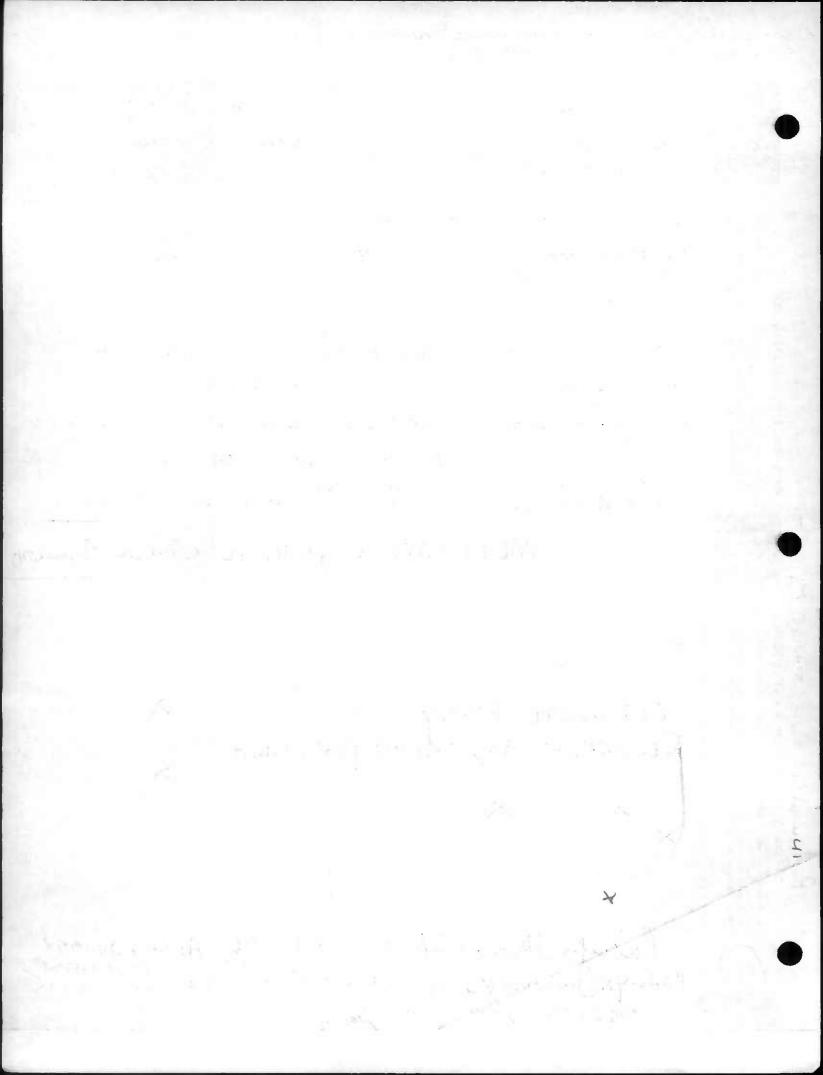
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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Months Days

Certificate of Death Reg. No.

State of Maryland / Department of Health and Mental Hygiene	8	21	0/

Hours

Physician
/Medical
Examiner

1. Decedent's Nama (First, Middle, Last) Earl Sylvester Reed 4a Facility Nama (If not institution, give street and number)

2. Data of Death August 13, 1998 ear

3. Tima of Death 6:20

Funeral

Gladys Spellman Nursing Home 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 6 Sev

XX M 2□ F

Cheverly

4b. City, Town, or Location of Death

4c. County of Death Prince George's

Director

28a-f show

Items 23a death

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Physician /Medical

Examiner

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Box

P.O.

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Division

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To the Hospital within 24 hours To the Funeral completely filled

Physician/Medical Examiner

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Completed

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Certification: To

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Completed

with the Maryland

72 hours after

Baltimore, Maryland 21215-0020

Usual Residence of Decedent 10s State 10h County

10c. City, Town or Location

83 Yrs.

Hours Min. 8. Data of Birth Month, Day, Year 99. Birthplaca (State or Foreign Washington, D.C.

Director

Maryland Prince George's

Hyattsville

10d. Inside City Limits MYas 2 No

10e. Street and Number

577-05-3101

6621 22nd Place

10f. Zip Code 20782 10g. Citizen of What Country? United States

16b. Kind of Business/Industry

11 Marital Status

1 Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U,S. Armed Forces? XXI Yas 2 □ No If Yes, Giva Year or Dates: WWII

College (1-4or 5+)

 Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 1 Yes XX No Specify:

14. Race - American Indian. Black, Whita, atc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Sheet metal worker

Randolph Sheet Metal

Elementary/Secondary (0-12) 17. Father's Nama (First, Middle, Last)

John Sylvester

18. Mother's Name (First, Middle, Maiden Surname)

unknown

19a. Informant's Name/Relationship (Type, Print)

John Sylvester Reed (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11600 Amelia Street Beltsville, Maryland 20705

20a. Method of Disposition

1XXBurial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

20c. Location - City or Town, State

21. Signature of Funeral Service License

22. Nama and Address of Facility
Donald V. Borgwardt Funeral Home, P.A.

Maryland Veterans Cemetery 8/17/1998 Crownsville, Maryland

23a. Part1. Entar the diseasa, or shock, or heart faitura. List on

4400 Powder Mill Rd. Beltsville, Md. 20705 that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, churs on each line.

Immediata Causa (Final disease or condition resulting in death)

ANTENIOSCIEROTE CARDIOVASCULAR DISCOSP Due to (or as a consequence of):

Approximate Interval Between Onsat and Death Years

Due to (or as a consequence of):

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco usa contribute to the cause of death?

Respiratory failure, Alzheimen's Disease

1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed?

PArkinson's Disease, multiple Decubiti

Encephalopathy

1 ☐ Yas 2 No

24b. Wera autopsy findings available prior to completion of cause of death?

Dysp hagia 25. Was case referred to medical axaminer?

Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA

26. Place of Death (Check only one)

1 Yas 2 No

1 Yas 21 No 27. Manner of Death

2 ☐ Accident

3 Suicide

4 ☐ Homicide

5 Pending invastigation

28a. Data of Injury (Month, Day Year) NIA

Other: Nursing Homa 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

29a. Certifier

6 Could not be 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certified

29c. License number 1)01852 29d. Data signed (Month, Day, Year)

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) 4203 Queensbury Rd Hyathville MD 20781

MD 31. Data filed (Month, Day, Year)

AUG. 1. 8 1998

32. Registrar's Signatura

State Registrar

DHMH 16 Ray 6/95

from the fronter

506 F F 2012

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 01 1998 August 21:35 PM Marion Gertrude /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Hospital St. Mary's Leonardtown If Under 1 Year | If Under 24 Hrs. 5. Social Sacurity Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 2DXF Months Days Hours Yrs. Director 578-12-3233 78 November 27, 1919 Washington D.C. Usual Residence of Deceden the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland St. Mary's Hollywood 10e. Streef and Number 10f. Zip Code 10g. Citizen of What Country? 44996 Blackistone Circle 20636 U.S.A. Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Nevar Married 2 N Married Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2 X No Specify: White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mentel Hygiene. Important: If item 27 is marked other than any injury or other traumatic avant Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant State Government 12th 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edmund R. Wright Josphine J. Kelly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carrollton E Reese/Husband 44996 Blackistone Cr., Hollywood, MD 20636 20b. Place of Disposition (Name of cemetary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donafion 5 ☐ Other (Specify) 8/5/98 St. John's Cemetery Hollywood, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Mattingley-Gardiner Funeral Home, P.A. P.O.Box 270, Leonardtown, MD 20650 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or raspiratory arrest, shock or heart failure. List only one cause on each line. Approximata Intervat Between Onset and Death **Physician** Stem revelval Voscular accedent /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner Moxa The law requires that the death certificate be executed physician end s the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or as a consequance of): ettending p Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? the s been signed by the 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown PV Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? pege 2 2/5 No After this certificate 1 Yes 2 40 within 24 hours efter death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 110 Other: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 patient 2 ER/Outpatiant 3 DOA Certification: To 28a. Date of injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. fnjury at Work? 1 Matural 2 ☐ Accident or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be detarmined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide o the Hospital 15 Certifying Physicien: To the best of my knowledge, death occurred af the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Fu 29c. License number 29d. Date signed (Month, Day, Year)

D31952

California, MD 20619

State Registrar

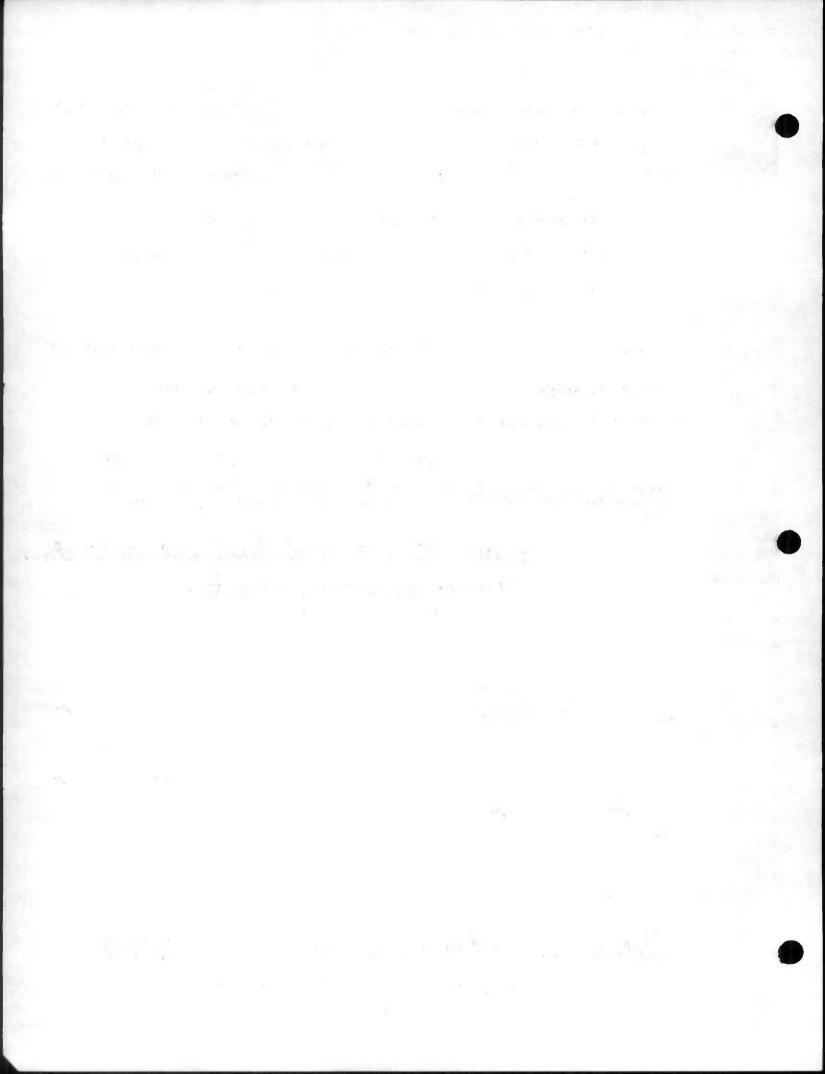
Michael S. Szkotnicki, MD Jelia d'audean Rardall 31. Data filed (Month, Day, Year) AUG 04

e of death (Item 23a) (Type, Print)

ne and address of person who completed a

DHMH 16 Rev 6/95

Marion Gertrude Reese

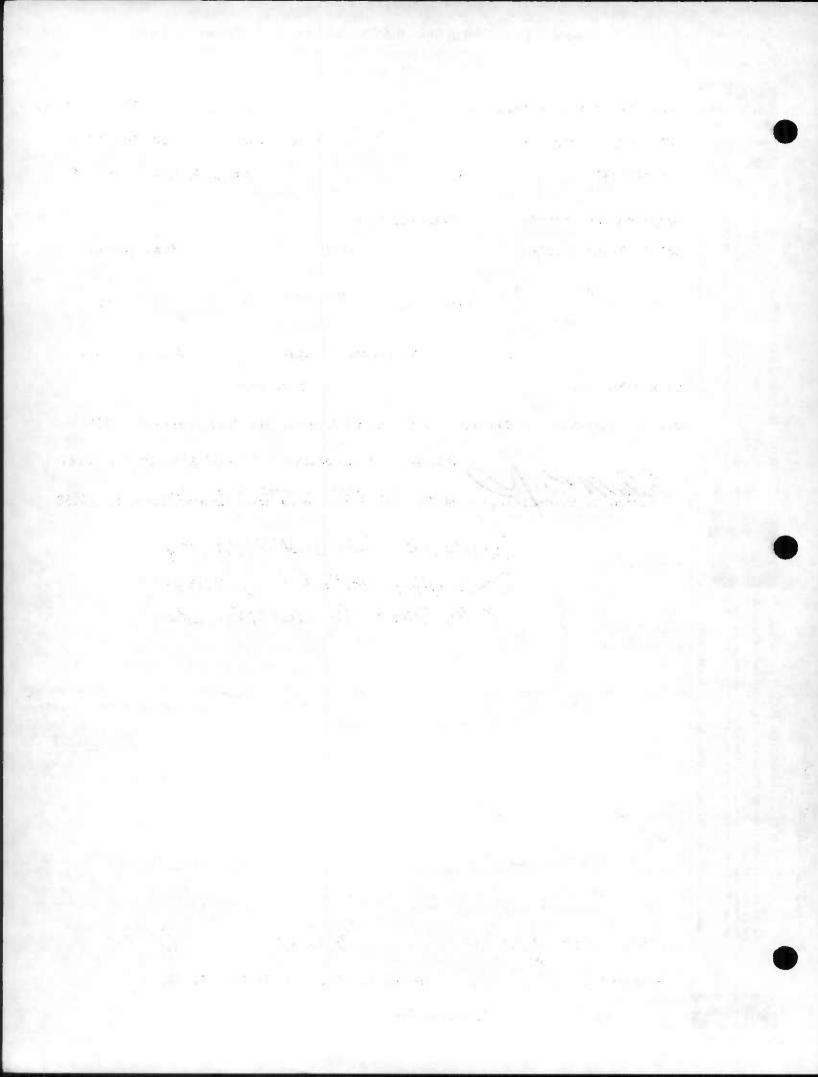


State of Maryland / Department of Health and Mental Hygiene

					Cel	tificate of	Death			Reg. No.		
	Physician	1. Decedant's Nama (First, Middle							2. Date of De Month	Day	Yeer	3. Time of Deeth
	' /Medical	Patrick Charle							August		998	2:33 AM
	Examiner	4a Fecility Name (If not institution		imber)		-, -			cation of Deat	1000		
		St. Mary's Hos	6. Sex	7 Aco //o um	lo at hirthday	If Under 1 Yas	Leona r If Undar				Mary	
ı	Funeral Director	185-20-4240	1.3xM 2□ F	7. Aga (in yrs. 74	Yrs.	Months Day		Min.	8. Date of Bi (Month, Di January		Coun Ire	lece (State or Foraign itry) Land
	pue *	Usual Residence of Decedent 10e. State 10b. County		10c. Ci	ty, Town or Lo	cation					1	0d. tnside City Limits
	iter deeth with the Meryland r items 23s or 28s-f show niner must be notified at Funeral Director	Maryland St. N	Mary's	Lex	ington	_						1 ☐ Yes 2 No
	or 2 Dire	10e. Street end Number 46101 Pleasant	Drive			10f. Zip Code 2065				10g. Citizen of United		
	seth with	11. Marital Status		sedant Ever in U	IS 13 1			igin? (Spe	ecify Yas or N		ea - Americ	
0	or its	1 □ Never Merried 2 ☑ Merr	Armed F	orces?		Was Decedent of t Yes, specify Cu 1 ☐ Yas 2 🛣 No			Rican, etc.)	Bia Specif	ck, Whita,	etc.
00	"natural", o	3 Widowed 4 Divorced	Year or I	Dates: 1950							Wh	ite
21215-0020		15. Deceden (Specify only highes	t's Education st grede completed))	(Giva	dent's Usual Occi kind of work don DO NOT usa ratii	e durina mos	t of worki	ing	16b. Kind ot B	usinass/in	Justry
212	within fene.	Elemantary/Secondery (0-12)	College ((1-4or 5+)			Manager			Grocei	ore	
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/lar	Menta	George Ramplin					Elle	n Ta	1ty			
Maryland	2 should be fend Mentel is marked of sumatic every	19a, Intermant's Name/Relations	hip (Type, Print)		19b. Mailir	ng Address (Stre	et end Numbe	er or Rura	al Routa Numb	er, City or Town	, Stete, Zip	Code)
	ges 1 and 2 should be filed within to fleatilh and Mental Hyglene. If item 27 is marked other than or other traumatic event, the Merchen To Be Comp	Mary E. Ramplin	n, Da	ughter		shland A	venue,	St.				
Ore	Pages 1 nent of H int: if iter	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion	3 ☐Removei from		Piace of Dispo cemetery, crer	sition (Name of natory or other p	laca)		Date	20c. Location	,	
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Bal	permit. Pa Departmen Important: any injury once.	21. Signiture Coneral to 10g	W/1			Name end Add		•	Home.	Р. А.		
		Edward N. Bi 23a. Part1. Enter the disease, or	Control of the Land College of the Land Colleg	Jr. MO		rinsfiel 2955 Hol					ı, MD	20650 Approximate
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	Physician /Medical	Immediete Cause (Finei	7	CHE	MIC	CAR	101	MX	PAT	71		
	Examine: .	disease or condition resulting in death)	a	ODue to (or asia consel		_ 1	1	1			
L	e e	CHEST THE STATE OF	Q	DRON	ARY	1414	244	1	180	ASCE		
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60,	be ex ician bune	if any, leeding to immediata cause. Enter Underlying Causa (Disaasa or injury	C	51017	VINC	16 PC	-40 11-	- /	1112	JAC		
68760,	certificate be iding physicia ise as the bu	that initiated events resulting in death) Last		Due to (d	or es a conseq	uenca of):						
XO.	ndin use		d									
B.	es that the death igned by the etten be deteched for u by Physiciar	Part II. Other significant conditto	ons contributing to d	leath but not res	sulting In the u	ndarlying cause	riven In Part I	1	23h. Did	tobacco use co	ontribute to	the cause of death?
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Vita	entific ector Be	25. Was case reterred to medica examiner?					The state of the s	e of Deat	h (Check only	ona)		
of	this aid	1 Yes 27. Manne of Death	Hospitai: 1 12		ER/Outpetier 28b. Time o	IT 3LI DUA				idanca 6 Oti		(V
LO U	ding I h. After fune tion	1 Naturai 5 Pendin	ig (Mor	nth, Dey Year)	Injury	W	ork? □Yas 2□		Zou. Describe	now injury occu	1100	
Division	Attending in deeth. actor: Afte by the fune fification	2 Accident invastig	not be	a ot tnjury - At h	ome, tarm, str	eet, factory, offic			28f. Location	(Street end Num	ber or Rura	al Route Number,
ā	ttal or Attending Pars efter deeth. Tal Director: After teled in by the funers Certification:	4 HomicIda	build	ting, atc. (Speci	<i>(hy)</i>				City or To	iwn, Stete)		
	Hosp 24 hou Fune stely fil	29a. Cartifiar (Check on Medical	g Phyaictan: To the Examiner: On the b									
	within To the comple	29b. Signature and title of cartifie	1/2/	000		29c Lice	nse number	,		29d. Bate sign	to Blocky	Dey, Year)
		Meselle	V			2	5004			8/11/	18	
		30. Name and address of parson TERRENCE R.	who complated cau BERTELE M			Print) AKLEY ST	LEON	NARDI	rown, md	. 20650		
	State Registrar	31. Date filad (Month, Dey, Year) AUG 1		Registrar's Sign	Lon-Roy	1.1!						
			1									

DHMH 16 Rev 6/95 4+19

PATRICK CHARLES RAMPLIN



Please Type or Print In Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

to a standing Physician. The law requires that the death certificate be executed.	P	Baltimore, Maryland 21
	hysici /Medi ixamir	Department of Health and Mental Hygiens Important: if item 271s marked other the

MICHAEL HEN	RY RUSIN			ate of Death		eg. No.			
Physician	1. Decedent's Nema (First, Middla, Las				2. Deta of Dea Month	Day 1998	3. Time of Deeth		
/Medical	Michael		Rusin	4h City Town or	AUG.	4c. County of			
Examiner	4e Fecility Neme (If not institution, give 20001 BUCK LODGE			BOYDS	LOCATION OF DOCUM	MONTG			
Funeral	5. Sociel Security Number 6. Sec			der 1 Year If Undar 24 Hrs			Birthplece (State or Foreign Country)		
Funeral Director		X M 2□ F	58 Yrs. Month	s Deys Hours Min	Mar. 2	6 1940	IL U.S.A.		
yland	10a. Stata 10b. County	10c. (City, Town or Location				10d. Inside City Limits		
Mar a-f et ared ctor	MD Montgom	ery		Boyds			1 ☐ Yas 21 No		
Office death with the Mar river as 23 or 23s-1 s increment be confised Funeral Director	10e. Straat end Number 20001 Bucklodg	e Rd	10f.	Zip Code 20841	1	l0g. Citizen of Wh	U.S.A.		
	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Wes Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates:		cedent of Hispanic Origin? (Specify Cuben, Mexican, Pual 2X) No Specify:	Specify Yes or No- to Rican, atc.)	14. Race Bleck, Specify:	Americen Indien, White, etc. White		
5-0 72 ho	15. Decedent's Ed (Specify only highest gre	ucation de completed)	16e. Decedent's U	sual Occupation work done during most of wo use retired)	of working 16b. Kind of Business/Industry				
1 21215-002 led within 72 hours of bygiena. her than "naturel", of rt, the Medical Exa Completed by	Elementery/Secondary (0-12)	College (1-4or 5+)	life. DO NOT	use retired) ECONOM		A. P. I.			
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aryla should nd Men marke Imatic	John Rusin 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, 2								
and 2 sauth ar n 27 is	Dorothy A. Trac	wile		ucklodge Ro					
s 1 a la l	20e. Mathod of Disposition	20b	. Place of Disposition (I cemetery, cremetory of	Verne of	Dete		ity or Town, Stete		
Pages nent of mr: If it	1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specify	Removal from State	inders & S		8/24	Berryvi	lle, VA		
Baltimore, Meemit Pages 1 and Department of Health Important: If item 27 any Injury or other trees.	21. Signeture of Funeral Service Lican	saa	22. Name	end Address of Facility	Home				
_ 402.64	23a. Part1. Enter the disease, or comp shock, or heart feilure. List only	Helt	Bar	nesville,	4D 20838	3	Approximete		
that the death certificate be executed ed by the attending physician and deteched for use as the bunal-transit of Physician/Medical Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceusa (Disease or injury that initiated events resulting in death) Lest	b. Due to	(or es a consequence of or es a consequence of or es a consequence of or es e consequence or es e conseque	of):)				
P.O. BOX nat the death cert d by the attendin leteched for use Physician/N		d					1		
the dea by the at sched fo	Part II. Other significent conditions co	ontributing to death but not re	esulting in the underlyin	g ceuse given in Part I.	23b. Did to	obacco use cont	ribute to the cause of death?		
ords, P.O. Box requires that the death cer een signed by the attendir hould be deteched for use sted by PhysicianA					101	/es 2□No	3 ☐ Probably 480Unknow		
Die 2 s b					24e. Wes e perfor		24b. Wera eutopsy findings svellable prior to completion of ceuse of deeth?		
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Vital Richard The cartificate rector, pag	25. Wes case referred to medical exeminer?	16			eth (Check only or	ne)			
this ald district the state of	27. Menner of Deeth 1 KNaturel 5 Pending	28a. Date of Injury (Month, Dey Year)	ER/Outpetient 3 28b. Time of Injury M	DOA Other: 4 Nursing 28c. Injury et Work? 1 Yes 2 No	Home XX Resid	ence 8 DOther			
Division (To the Hospital or Attending P within 24 hours after death. To the Funeral Director: Aftert completely filled in by the funeral Medical Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined			tory, office	28f. Location (S City or Tow	Street and Number n, State)	r or Rural Route Number,		
n 24 houn n 24 houn he Funera pletely fille	29e. Certifier 1 Certifying Phy (Check only cont) Medical Example	ysician: To the best of my killner: On the basis of exemi	nowledge, deeth occurr netion end/or Investigat	ed et the time, dete end pled ion, in my opinion, deeth occ	e, end due to the curred et the time, o	euse(s) end men dete end place, ar	ner es steted. nd due to the cause(s)		
o the complete	290. Signature and title of dertifler)		29c. Licansa number		29d. Date signed	(Month, Dey, Year)		
F \$ F 0	1	You		O.C.M.E		AUG. 22	., 1998		
	30. Name and address of person who	completed cause of deeth (It		Street, Balt:	imore, Ma	ryland 2	21201		
State Registrar	31. Dete filed (Month, Day, Year)	32. Registrar's Sig		Ana X					

State of Maryland / Department of Health and Mental Hygiene

						Certificate of	of Death	R	eg. No.		
	Dhuais		1. Decedent's Nama (First, Middla, Li	ast)				2. Data of Deat			3. Time (Leath
	Physic /Medi		MR. HOWARD EUG	ENE ROBB				AUGUST	P8,199	980	11:13 M
	Exami	ner	4a. Facility Nama (If not institution, git)			VILLE	4c. County	of Death EDERIC	K
			11305 BROOKSIDE			T WILL A SA					
	uneral irector		488-28-8749	Sex 7. Ag	ga (In yrs. last b	Yrs. If Undar 1 Y Months De	aar If Undar 24 Hr ays Hours Min		Year) , 1926	9. Birthplac Country Arkan	e (Stata or Foraign) Sas
and	ž		Usual Rasidance of Decedant 10a. Stata 10b. County		10c. City, To	wn or Location				10d	. Inside City Limits
Maryl	-faho	ō	Maryland Frederi	ck	Ijams					133	1 ☐ Yas 2 No
the	7.28a	Director	10e. Street and Number	- CIC	LJams	10f. Zip Coo	da	1	0g. Citizan of V	Vhat Country	?
h with	30 0	0	11305 Brookside (Court		217	54		U.S.	Α.	
Baltimore, Maryland 21215-0020 semit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland	in or result and western trypeler. If them 27 is marked other than "natural, or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funerai	11. Maritai Status 1 Navar Marriad 2 Married 3 Widowed 4 Micropole	12. Was Decedant Armed Forcas' 1X Yas 2 1 If Yas, Giva Yaar or Datas:	?	13. Was Decedant If Yas, specify (of Hispanic Origin? (Cuban, Maxicen, Pua No <i>Specity:</i>	Specify Yas or No- rto Rican, atc.)		e - Amaricen ck, Whita, ato Whit	9.
5-0 72 hg	natur	pet	15. Decedant's E (Specify only highast gr		16	a. Decedant's Usual Oc	ccupation	ant in a	16b. Kind of Bu	usinass/Indus	itry
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d 21	other th	Co		6+		Chemical	Engineer		NIST	711	
anc be fi	a ver	Be	17. Fathar's Nama (First, Middla, Last John Howard Robb)				ama (First, Middla, I		ia)	
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	/sician ledical		Immediata Causa (Finai	CALL	1	Μ	LTIFORM			3.0	11
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ecords, P.O. Box 68760, law requires that the death certificate be executed	ettending physician end for use as the buriel-transit	Examiner	Sequentially list conditions	b	Dua to (or as a	consaquance of):					
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Box	tendi			d							
O. B	ed by the ettend detached for us	Physician/	Part II. Other aignificant conditions of	contributing to death b	out not rasulting	in the underlying coust	a givan in Part I.	23b. Did to	bacco use cor	ntribute to th	ne cause of death?
P.O.	d by letach	F.						1 🗆 Y	es 2 No	3 Probet	oly 4 Onknown
JS,	been signed to should be det	by									
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e ĕ	e 2 s	npie								of das	plation of ceuse ath?
<u>م</u> ۽	pag.	S						1 □ Ya	as 2 No	1 🗆 Y	as 20 No
Vita	s certificate has director, page 2	Be	25. Was cesa rafarrad to medical axaminar?	11				aath (Chack only on	ia)		
DIVISION of Vital Records, or Attending Physician: The law requires the identity.		2	1□ Yas 2 No	Hospitel: 1 Inpati				Homa Rasida			
E ing	After	on	27. Manner of Daath 1 Staturel 5 Pending	28a. Data of Inju (Month, De	y Year) 28b.		Injury at Work?	28d. Dascribe ho	ow injury occur	red	
ISIO kttendii death.	Director: After	cat	2 Accident invastigatio	a one Disease (In	ium. At home		1 Yes 2 No	28f. Location (St	tract and Numb	or or Pural D	Pouts Alumbas
Or A affer	Dir b	Certification:	4 ☐ Homicide determined		c. (Specify)	farm, street, factory, off	ice	City or Town		er or narar n	outa Number,
DIVI To the Hospital or Att	To the Funeral Director: After the completely filled in by the funeral	edical C	29a. Certifier 12 CertifyIng Pr	niner: On the basis o	f axamination e	ge, daath occurred at th nd/or investigation, in n	e time, date end plac ny opinion, deeth occ	e, and dua to tha courred at the time, d	ausa(s) and ma ate end plece, o	inner as stete end due to th	ed. le cause(s)
o the	o the	Mec	29b. Signature and the of pertifier of	and mannar st	a190.	29c Lie	cansa number	2	9d. Date signa	d (Month De	v. Year)
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			TELL	~	<u>"</u>		J J-3		10001	17,	,10
			30. Nama and addrass of parson who		saath (Itam 23a)	(Type, Print)	7			00-	
			rosely Kuchun	11181	Thinu	J. Will	Dr. OL	"NEY, N	10 5	083.	2

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Registrar

Proprieta

State of Maryland / Department of Health and Mental Hygiene 27082

							Cer	tificate of	Death		Reg. No.		
	Physic		Decedent's Name	(First, Middle, La Wilbert	•	RINEHA	RT			2. Date of De Month August	Day -	98 ^{ear}	3. Time of Death 9:50 AM
	/Medi Examii			not institution, gi s Nursin	ve street and number,)			4b. City, Town, Frede	or Location of Deat	h 4c. County	_	
	Funeral Director		5. Social Security N 217-10-04	91	VV =	ge (In yrs. last 88	birthdey) Yrs.	If Under 1 Year Months Days	if Under 24 H Hours M	tin. 8. Date of Bi (Month, D March	rth ey. Yeer) 20,1910	9. Birthy Cour Mar	place (Stete or Foreign ntry) yland
	and and		Usual Residence of 10a. State	10b. County		10c. City, To	own or Loc	cation					10d. inside City Limits
	Sa-f ehc	Director	Maryland	Frederi	ick		deric	k					XX Yes 2□ No
	h with ti	ai Dire	10e. Street and Nun	nil Avenu	ie			10f. Zip Code 2170	1		10g. Citizen of V.S.		ntry?
020	n 72 hours efter death with the Meryland "natural", or items 23a or 28s-f show solical Expredient must be notified at	by Funeral	11. Marital Status 1 ☐ Never Marrid 3 ☑ Widowed	ed 2 Married	12. Was Decedent Armed Forces 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:	Ever in U,S. No		Vas Decedent of H Yes, specify Cube	lispanic Orlgin? an, Mexican, Pu Specify:	(Specify Yes or No erto Rican, etc.)	Blac	e - Americ ck, White, v: Whi	
0-0	2 hou			15. Decedent's E	ducation	10	6a. Deced	ent's Usuai Occup	ation		16b. Kind of 8	usiness/In	dustry
2121	C . 38	Completed	Elementary/Secon	ify only highest grandery (0-12)	College (1-4or	5+)	(Give kind of work done during most of work life. DO NOT use retired) Supervisor/ Electrician			working	City Go	ment	
Baltimore, Maryland 21215-0020	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If Item 27 is marked other than any Injury or other traumatic event, the Monce.	Be	17. Father's Name (First, Middle, Last	")	Rineh	art			Name (First, Middle	, Maiden Sumen		
ary	Shoul mark mark	70	19a. informant's Na		(Type, Print)			a Address (Street		Rurel Route Numb			n Code)
Ž	alth a		Clarence							Frederic			
ore,	other other		20a, Method of Disp	osition			of Dispos	sition (Neme of setory or other ples		Date	20c. Location -		
<u>iii</u>	Pege nent ant: If ury or			☐ Cremation 3 ☐ 5 ☐ Other (Speci	Removal from State (fy)			t Cemetery		17, 1998	Frederi	ck, 1	Maryland
Balt	permit. Depertrimportu		21. Signature of Fur	neral Service Lice	My /	M00255	E		nd Basfo	ord PA Fu			
			23a. Part1. Enter th	e disease, or com	nplications that cause one cause on each li		110)6 East (or the mode of dyin	church S	St., Fred diac or respiratory a	lerick, l	MD 21	Approximate
	Physician		Shock, or near	t reliure. List only	one cause on eech ii	ine.						i	Interval Between Onset and Death
	/Medical Examiner		immediete Ceuse (I disease or condition	Final	Ro	uto	ma	D. in	archi	toi			24 Hans
	Lxammer	_	resulting in death)		u	Due to (or as	a consequ	uence of):					
Т	bet isit	nine			b. —								
,	certificete be executed nding physicien end use es the buriel-trensit	Examiner	Sequentially list con if any, leading to im- cause. Enter Under Cause (Disease or I that initiated events	nditions, mediate		Due to (or as	a consequ	uence of):				i	
68760,	ysicle		Cause (Disease or i	njury	c	Due to (or as	a consequ	ience of):					
89	ng ph	//Medical	resulting in death) L	ast		200 (0 (0) 00	u 001.0040	01100 017					
Box		an			d							-	
P.O.	the e	Physician	Part li. Other algnifi	cant conditiona	contributing to death b	out not resulting	g in the un	derlying cause giv	en in Pert i.	23b. Did	tobacco use co	ntributa t	o the cause of death?
	ires that the death signed by the ette d be deteched for	by Ph								1 🗆	Yee 200 No	3 ☐ Pro	bably 4 Unknown
Vital Records,	neen houl	Completed b								24e. Wes	en autopsy ormed?	av	ere autopsy findings vallable prior to completion of cause
Rec	S C	du				-					1-4	of	death?
<u>a</u>	certificate rector, pa		25. Was case refern	ed to medical					00 00	10	/	1 [☐ Yes 200 No
	Physician: this certific ral director,	o Be	examiner?	a a	Hospitai;	ent 2 ER/	Outpatient	3□ DOA Oth	00 100	Death (Check only g Home 5 Res		er (Snecil	(v)
on of	th. After this funeral di	tion: T	27. Menner of Death	5 Pending	28a. Date of Inju (Month, De	ıry 28t	o. Time of injury	28c. Injur Wor		T	how injury occur		77
Division	To the Hospital or Attending Physician: The I within 24 burs effect death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of in	jury - At home, c. (Specify)	farm, stre	et, factory, office		28f. Location (City or To		er or Rure	el Route Number,
	Hospital	edical C	29a. Certifier (Check only	Certifying Pt	nyaiclan: To the best miner: On the besis o	t examination	ge, death	occurred at the tin	ne, date and pla	ace, and due to the	cause(s) and ma	nner as a	itated.
	ithin 2 the omple	Med	one) 29b. Signature and t	7	end manner st	ated.		29c. Licens			29d. Date signe		
	F 3 F 8		7	Ans	for Ka	hour	-	- Comment	397	1	August		
			30. Name and addre	ss of person who	completed cause of	leath (Item 23)			0 2	1701			
	Sta	te	31. Date filed (Mont	Day, Year)	32. Registr	ar's Signature	110	forms	Ud	1/01			
	Registr	ar	A	M I / 19	98	nsarar	6	Ara.					
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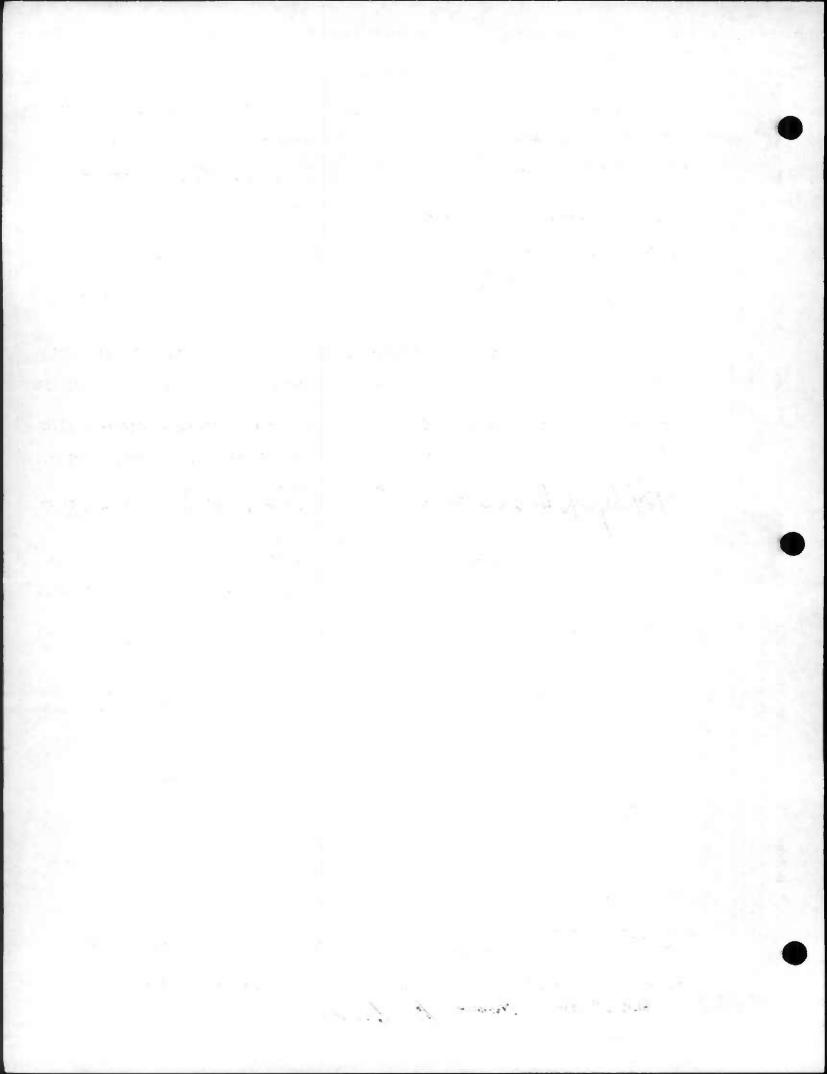
State of Maryland / Department of Health and Mental Hygiene

27083

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Physic		Margare		zahe	th	RUSSE	T.T.	Month August	Day	Yaar 998	11:00 pr
/Medi Exami		4a. Facility Name (If not institution, giv	va street and number)	Zabc	CII		4b. City, Town, or i				111;00 pr
		1613 Shooksto	wn Road				Frede	rick	F	rede	rick
Funeral Director		220-18-3397	Sex 7. Aga 1 M 2 F	a (In yrs. las	st birthday) Yrs.	If Undar 1 Yaar Months Days	If Undar 24 Hrs. Hours Min.	8. Data of Bird (Month, Da Apr 25	th y, Year) , 1921		placa (Stata or Forentry) yland
DU .		Usual Residence of Decedant 10a. Stata 10b. County		10c City	Town or Lo	cation				Т.	
a-feho	ctor	Maryland Freder:	ick		ederi					'	10d. Insida City Lim 17€ Yas 2
3a or 28	I Dire	10e. Street and Number 1613 Shookstown	Road			10f. Zip Coda	21702		10g. Citizan of U.S		ntry?
perinit. Fages I ento 2 should be lied within 72 hours after death with the Merylend Dependent of Health and Manalla Hygiane. Dependent of the marked other than "natural", or flems 23s or 23s-f show any injury or other treumatic event, the Med call Example mant to notified at once.	by Funeral Director	11. Marital Status 1 Navar Marrlad 2 Marrlad 3 Widowad 4 Divorced	12. Was Dacedant B Armed Forcas? 1 ☐ Yas 2 ☑ N If Yas, Giva Yaar or Datas:			Was Decedant of Information of Info					
natur	ted	15. Decedant's En (Spacify only highast gra	ducetion		16a. Decedent's Usual Occupation (Giva kind of work dona during most of work life. DO NOT usa ratired)			rorking 16b. Kind of B		of Businass/Industry	
. Fa	(Spacify or Users of Control of C		College (1-4or 5	i+)	Iffe. DO NOT usa ratired) Teacher/Music						
ygian r, th	Co		5+		Tea	cher/Mus					ol Syste
fantal H rked ott	To Be	17. Fathar's Nama (First, Middla, Last, Guy	C			THOMAS	18. Mothar's Nar	na (First, Middla,	Maidan Sumar Helen	na)	DILLE
s ma		19a. Informant's Name/Ralationship (Typa, Print)		19b. Mailin	ng Address (Street	and Number or Ru	ral Routa Numbe	ar, City or Town	, State, Zip	Coda)
n 27 l		Mr Richard R. Bu	urgee/Per.I	Rep.	30 W	est Patr	ick Stree	t, Frede	erick,	Mary1	and 2170
ant of He it: If item y or oth		20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Cramation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spacif		cen	ca of Dispo	sition (Nama of natory or othar pla		Data	20c. Location	- City or To	
ortan Injur		21. Signature of Funeral Service Liper	4			. Nama and Addra		, 1,,,,	I L CUCL.	LCIC	riar y rano
Depe Impo any ir		1 Kyl (1)	6 -		K	Keeney &	Basford				
nysician		23a. Part1 Enlar the dillease, or com shock, or heert fathera. List only	plications that caused one cause on each lin	MOO70 the death.	Do not anti	ar the mode of dyl	ch Stree	t, Frede	erick, I	Maryla	and 2170
•							.,,		rage,		
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DHMH 16 Rev 6/95

Registrar



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Dacedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death **Physician** Month Marvin Eugene Schneider 24, 1998 2:03 PM August /Medical 4a. Facility Nama (If not institution, giva straat and number) 4b. City. Town, or Location of Daath 4c. County of Death Examiner Harford Memorial Hospital Havre de Grace Harford 7. Aga (In yrs. last birthday) If Undar 1 Yaar | If Undar 24 Hrs. 5. Social Sacurity Number 8. Data of Birth (Month, Day, Ya May 26, Birthplaca (Stata or Foraign
 Country) **Funeral** 1⊠M 2□ F Days 509-32-3724 Kansas Director Usual Rasidanca of Decadant 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limita Harford 1 ☐ Yas 2 No Maryland Havre de Grace Director 10a. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 501 South Union Avenue 21078 U.S.A. 12. Was Decedant Evar in U,S Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - American Indian, Black, Whita, atc. 1 □ Navar Married 2 □ Married 1 ☐ Yas 2 ☐ No If Yes, Giva Yaar or Datas: 1 ☐ Yas 2 ☐ No Specify White þ 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedant's Education (Specify only highast grada complated) 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) 12 Military Sergeant 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) Be Theodore Schneider Martha Nuss 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Kevin Schneider/son unknown 20b. Placa of Disposition (Nama of camatary, cramatory or other placa) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Buriai 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 □ Donation 5 ₺ Other (Specify) in State 21. Signatura of Fundaral Service Licansee Conald S. Wade 22. Nama and Address of Facility State Anatomy Board, 655 W. Baltimore Street Director nan Baltimore, Maryland 21201 pations that causad the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Entar tha disaasa, or comp or haart failura. List on Interval Batwaan Onset and Death Physician /Medical Immediata Causa (Final disaasa or condition rasulting in daath) Examiner Dua to (or as a consaquenca of); Examiner Sequantially list conditions, if any, laading to immediate causa. Enter Underlying Causa (Disaasa or Injury that initiated avants rasulting in death) Last Dua to (or as a consequence of) Physician/Medical Dua to (or as a consequance of). Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings availabla prior to complation of causa of daath? 24a. Was an autopsy performed? Completed 25. Was casa rafarrad to medical axaminar? Be 26. Placa of Daath (Check only ona) 1 Yas 221 Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) P 2 ER/Outpatiant 3 DOA 27. Manner of Death 28d. Dascribe how Injury occurred Certification: 28b. Tima of 28c. Injury at Work? Natural 5 Panding invastigation 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not ba 28a. Place of Injury - At homa, farm, street, factory, offica building, atc. (Specify) 3 Suicida 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 Homicida Cartifying Phyalclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifiar Medical 29b. Sig 29d. Date signed (Month, Day, Yaar) omplated causa of daath (Itam 23a) (Type, Print) KEILCO 01 31. Data filad (Month, Day, Year) Registrar's Signatura State 4 1998 Registrar

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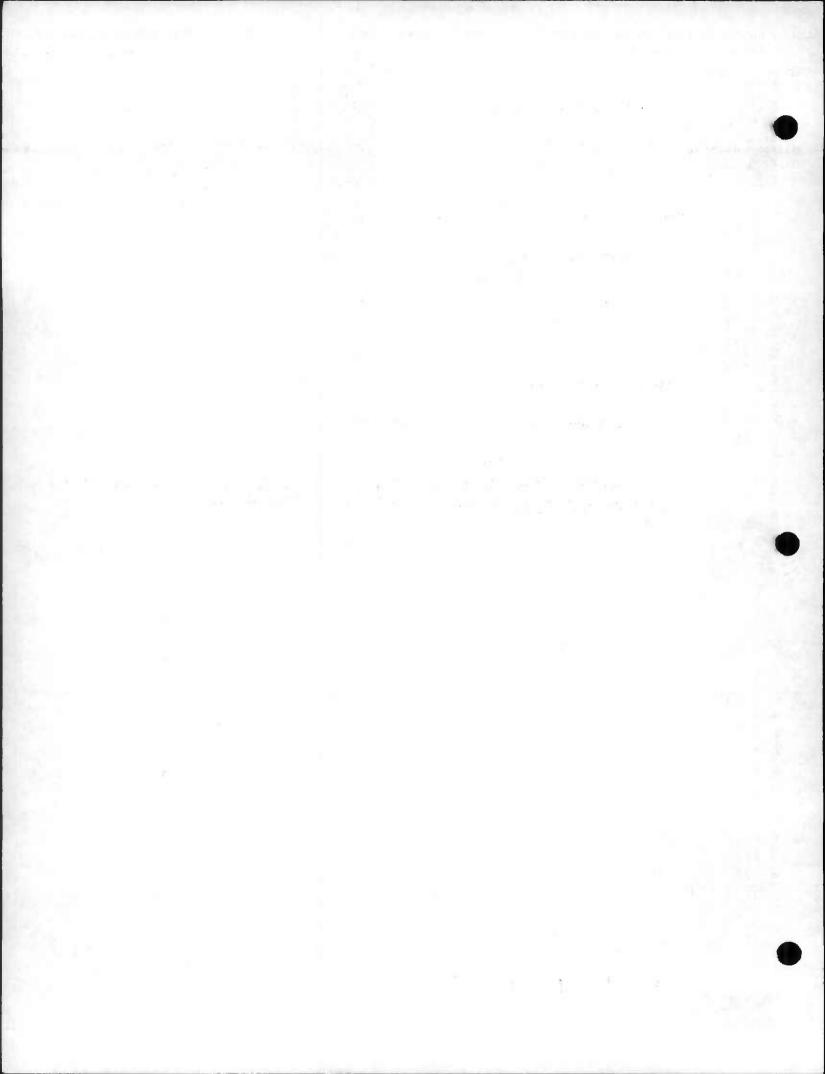
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Saltimore, Maryland 21215-0020



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Dete of Death Month **Physician** Gertrude Skylaske 8:36 22, 1998 August AM. /Medical 4a. Fecility Nama (If not institution, give streat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Harford Memorial Hospital Havre de Grace If Under 1 Yaar | If Undar 24 Hrs. 8. Dete of Birth (Month, Day, Year Dec. 13, 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□ M 2□F Days 79 Yrs. Director 214-01-3458 1918 Germany Usual Residence of Decedant 10e. Steta 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show the Medical Examiner must be notified at Director Harford 1 ☐ Yes 2 ☐ No Maryland Havre de Grace 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? ŏ 100 Revolution Street 21078 U.S.A. Неттв 23а Funeral 12. Was Dacedent Ever in U.S. Armed Forcas? unknown 1 □ Yas 2 □ No If Yas, Giva Yaar or Datas: Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxican, Puerto Rican, atc.) 14. Raca - Amarican Indian, Black, Whita, etc. 1 Navar Married 2 Married "natural", or 1 ☐ Yas 2 ☑ No Specify: Specify: White by 3 ₩ Widowed 4 Divorced Completed Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 15. Decedant's Education (Specify only highest grede complated) 16b. Kind of Businass/Industry I Hygiene. Elamantary/Secondary (0-12) Collega (1-4or 5+) permit. Pages 1 end 2 should be filed wit Deportment of Health and Mantal Hygiene Important: if Itam 27 is marked other tha any linjury or other traumatic event, I'm! unknown unknown unknown unknown 17. Fathar's Name (First, Middla, Last) 18. Mothar's Name (First, Middla, Maidan Surname) Be Johannes Wechmuller Lena Roell 19a. Informant's Name/Raletionship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Route Number, City or Town, Stata, Zip Code) George Leader/nephew 20a. Mathod of Disposition 20b. Placa of Disposition (Nama of cemetery, cramatory or other placa) Date 20c. Location - City or Town, Stata 1 ☐ Burlal 2 ☐ Cramation 3 ☐ Removel from State 4 □ Donation 3 ♥ Othar (Specify) in state 21. Signatura of Funaral Service Licerus ²² Name and Addrass of Facility State Anatomy Board, 655 W. Baltimore Street Director Baltimore, Maryland 21201 e. or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximeta Interval Batween Onsat and Deeth **Physician** MYOCA RAIAL INFARCT /Medical immadl Cause (Final disaase o condition resulting in daath) **Examiner** Examiner Sequentially list conditions, if any, laading to immediata causa. Entar Underlying Causa (Disaase or Injury that Initieted avants rasulting in daath) Last Dua to (or as a consequence of): Physician/Medical Due to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown page 2 should be dat Be Completed by 24b. Wara autopsy findings available prior to complation of cause of death? 24a. Was an eutopsy parformed? ABROMINAL ADRIC ANEURISM cartificate 1 ☐ Yas 2 No Hospital or Attending Physician: 24 hours aftar death. Funeral Director: After this cartifica 25. Wes casa raferred to medical exeminar? 26. Placa of Deeth (Chack only ona) Hospital: 1 ☐ Inpatiant 2 MER/Outpatient 3 ☐ DOA To 1 Yas 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 28a. Data of Injury (Month, Day Year) 27. Mannar of Death Certification: 28b. Tima of 28d. Dascribe how injury occurred 28c. injury at Work? 5 Panding Invastigation 1 Natural 1 ☐ Yas 2 ☐ No 2 Accidant To the Hospital or Atterwithin 24 hours after dea To the Funeral Director completely filled in by the 6 Could not be datermined 3 Suicida 28a. Placa of Injury - At homa, farm, streat, factory, office building, etc. (Spacify) 28f. Location (Straat and Numbar or Rural Route Number, City or Town, Stata) 4 Homicide edical Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and place, and due to the ceuse(s) end manner as steted.

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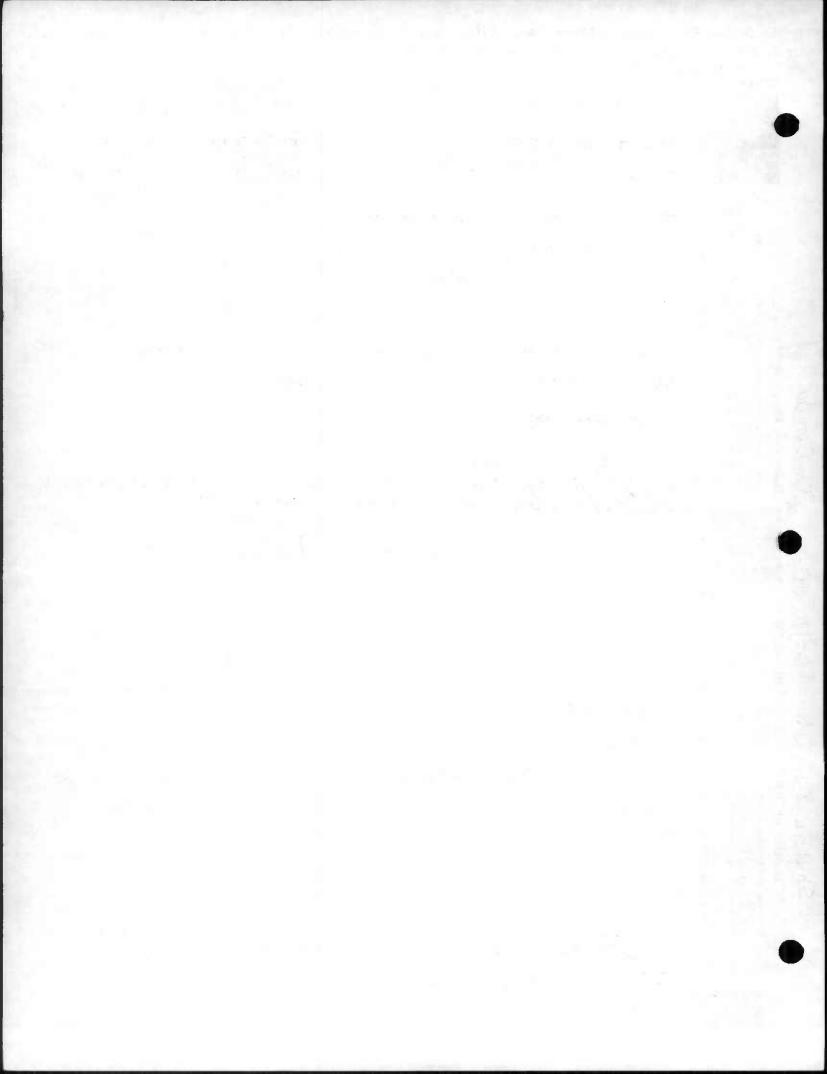
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Baltimore, Maryland 21215-0020

Dr Biondo

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DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death **Physician** William H. Smith /Medical 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner tmore 1aR4land GENERAL Baltimore City 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1₽M 2□ F Days Director Yrs. 216-30-8059 unknown Usual Rasidence of Decedent 10a Stete 10b. County 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Marylan nant of Heatth and Mental Hygiene. Int: if item 27 is marked other than "natural", or items 23a or 28a-f show iry or other traumatic event, in Medical Exament man is a notified at 10d. Inside City Limits 1 Tyyes 2 □ No Director Baltimore City Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1606 Mountmor Court 21217 U.S.A. Funeral 11 Marttal Status 12. Was Decedent Ever in U,S. Armed Forces?unknown Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Ricen, etc.) Race - American Indian, Bleck, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 21x Married 1 Yes 2 No Specify: Specify: Black by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Educetion (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) unknown unknown unknown unknown 17. Fathar's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Malden Surname) unknown unknown 19a. Informant's Name/Relationship (Type, Print) Important: if itam 27 is m any injury or other traum once. 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Coda) Emma Smith/wife 725 McKean Avenue, Baltimore, Maryland 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 ☑Othar (Specify) in state Signature of Funeral Service Licens State Anatomy Board, 655 W. Baltimore Street Wade, Director Baltimore, Maryland 21201 disease. of complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, failure. List only one cause on each lina. Approximete Interval Between Onset and Death **Physician** /Medical immediate Causa (Final disease or condition resulting in death) Examiner Examiner 5 bunial-tran Sequentially list conditions, if any, laading to immediate ceuse. Enter Undarlying Causa (Disease or Injury that initiated avants resulting In death) Last Due to (or as a consequence of): physician s the burial Physician/Medicai Due to (or as a consequence of): esn signed by the at the detached for Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by Completed 24a. Was an autopsy performed? 24b. Were autopsy findings eveileble prior to completion of cause of death? page 2 2 12 No 1 Yes 1 ☐ Yes 2 ☐ No funeral director. Be 25. Was cesa raferred to medical 26. Placa of Daath (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 1 Inpatiant Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) Location (Straat and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To tha best of my knowledge, death occurred at the time, date and place, and due to the ceusa(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier Medicai completaly 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Nama and addrass of person who complated ceuse of death (Itam 23a) (Type, Print) Maryland General Hospita H'AQ, M.D. 40 Ghazala

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31. Date filed (Month, Day, Year)

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32. Registrar's Signature

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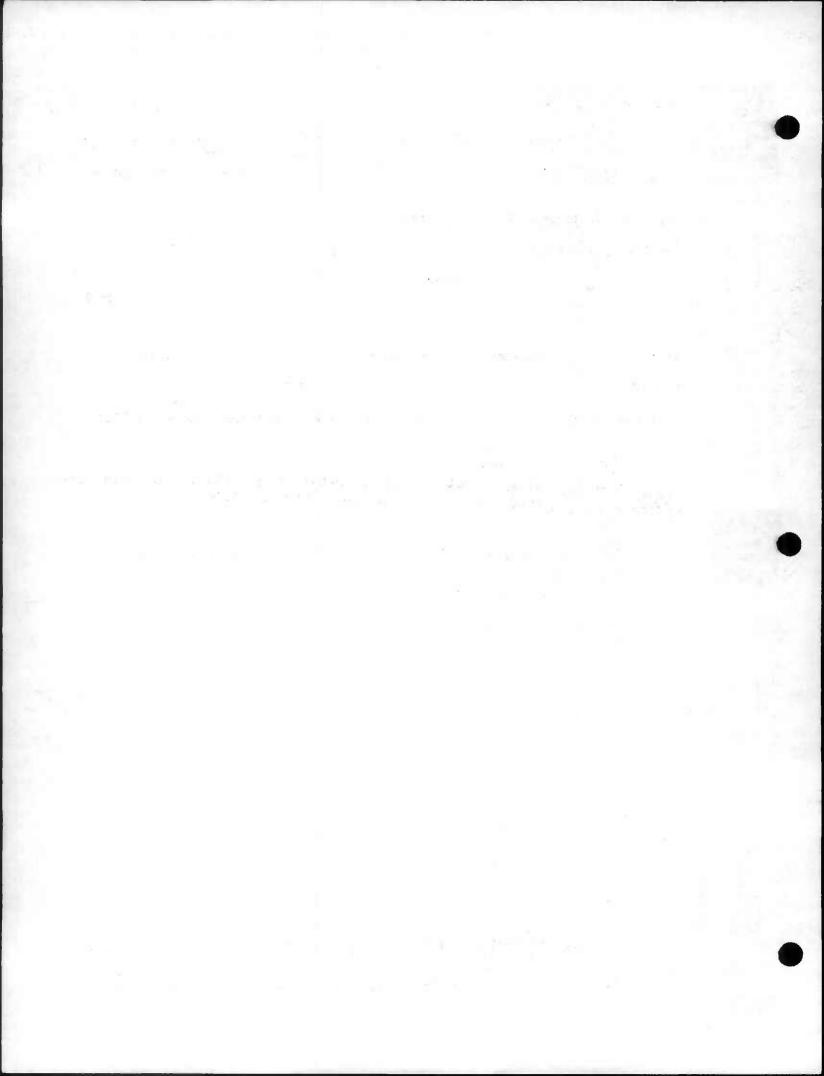
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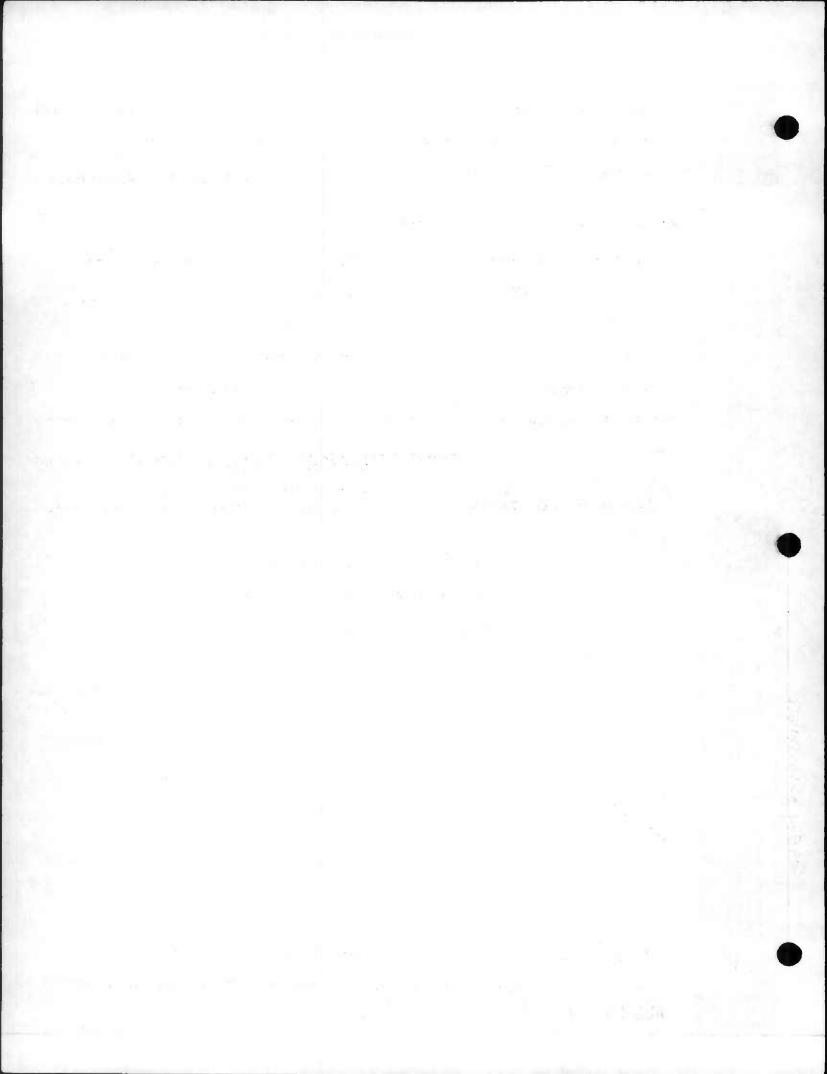
Hospital or Attending Physician:

To the



State of Maryland / Department of Health and Mental Hygiene

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** 17, 1998 2:55 AM DORIS ELIZABETH SMITH August /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Prince Georges 12319 Stonehaven Lane, #T-25 Bowie | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Pey. May 18, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (Stete or Foreign Country) **Funeral** 1919 1□ M 25F 579-22-3694 79 Yrs. Director Virginia Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 25a-f show ns 23s or 25a-f show must be notified at Maryland Prince Georges Bowie 1 X Yes 2 □ No Director 12319 Stonehaven Lane, # T-25 10f Zip Code 10g. Citizen of Whet Country? 20715 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Meritel Status the Medical Examiner 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Merried 2 ☐ Married 21215-0020 6 1 Yes 2 No Specify: Specify: Black by 3 C Widowed 4 ☐ Divorced natural Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) Hygiene. Elementary/Seco 12th condary (0-12) College (1-4or 5+) Technical Information Specialist U.S. State Dept. Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) 12 should be fi h and Montal H is marked off Be Ernest Stephens Emma Darden Pages 1 and 2 should 19a. informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) nt of Health a If Item 27 is or other tra William R. Smith, Jr. 1810 South Alsace Ave., Los Angeles, CA 90019 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 X Buriel 2 ☐ Cremetion 3 ☐ Removel from State Fort Lincoln Cemetery 8/21/98 Brentwood, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee Marshall's Funeral Home, Inc. 4217 9th Street N.W. Washington, DC 20011 complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, only one cause on each line. Approximete Onset end Death **Physician** Immediate Ceuse (Finel disease or condition resulting in death) /Medical . Hepatocellular Carcinoma 4 months **Examiner** Due to (or es e consequence of) Examiner b. Hepatitis C Infection 25 yrs. The law requires that the daath certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in deeth) Lest and Due to (or es e consequence of): the burial-tran Division of Vital Records, P.O. Box 68760, physician Physician/Medicai Due to (or es e consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of deeth? signed by t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Diabetes Mellitus À 24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? Completed 24a. Wes en eutopsy performed? peen Hypertension After this cartificata has Chronic Obstructive Pulmonary Disease 1 Yes 2 No 1 ☐ Yes 2 ☐ No Attending Physician: Be (25. Wes cese referred to medical 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 2 1 ☐ Yes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA s after death.
i Director: After this of In by the funeral d 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) Certification: 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending investigation 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street end Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide To the Hospital o within 24 hours af To the Funeral D completaly filled I 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 29a. Certifier Medical 2 Medical Exeminer: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end manner steted. 29b. Signeture end title of certified 29c. License number 29d. Dete signed (Month, Day, Year) MD D 50343 August 18, 1998 un 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Kelvin Hao, M.D. 3231 Superior Lane, Suite A-6, Bowie, MD 20715 31. Date filed (Month, Day, Yeer) 32. Registrer's Signeture State Registrar B. Spark

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State of Maryland / Departmen	t of Health and Mental Hygiene	0 1.100.

		A TANK LAND			Certificate	of Death		Reg. No.			
Physic	cian	1. Decedent's Name (First, Middle, Last) LINVILLE C, SCOTT						2. Date of Death Month Day Year 06;4			
/Med				MUQUS (), (10)							
Examin	iner	4e Facility Neme (If not institution, g	Location of Death			REEC					
Funera Director		3005 20th PLACE 5. Social Security Number 243-09-6353 6. Sex, 12M 2DF 86 Yrs. If Under 1 Year Months Days				ear If Under 24 Hrs	V 1				
Maryland 21215-0020 nd 2 should be filed within 72 hours after death with the Maryland tith and Mental Hypiene. 27 is marked other than "natural", or thems 23s or 28s-1 show or treumatic event, the Medical Examiner must be notified at		Usuel Residence of Decedent									
	Director	10a. Stata 10b. County					Inside City Limits				
		MARYLAND PRINCE		Yes 2 No. 10g. Citizen of What Country?							
	100	10e. Street end Number 3905 - 20TH PL		u. s. A.							
	To Be Completed by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	Armed Forces?	1 ☐ Yes 2 ☐ You 1 ☐ Yes 2 ☐			Specify Yes or No to Rican, etc.)	14. Race - American Indian, Black, White, atc. Specify: BLACK			
		15. Decedent's I (Specify only highest g	Education rade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most			orking	16b. Kind of B	ind of Business/Industry		
		Elamantary/Secondery (0-12)		Collega (1-4or 5+)				ROLLING PIN BAKERY			
		12TH GRADE 17. Fether's Name (First, Middle, Las	<i>t</i>)		BAKER	18. Mother's Na	me (First, Middle,			MLKY	
		UNKNOWN STELLA						HACKETT			
		19e. Informent's Neme/Reletionship		19b	. Maiting Addrass (Si	reet and Number or R	ural Route Numbe	er, City or Town	, State, Zip Coo	de)	
		DEBORAH LYLES -	DAUGHTER	3	905 - 20Tf	PL. HILL	CREST HE	IGHTS,	MD 2074	8	
altimore, mit. Pages 1: partment of He portant: If Item y Injury or oths ca.		20a. Method of Disposition Buriel 2 Cremetion 3 4 Donation 5 Oher (Special	□Removel from State	cemetar	Disposition (Name of the Colon CENT)	f place) IETERY	Dete 8/19/98		OOD, MD		
parmit. Departminents any inja		21. Signature of Funeral Service tricenses 22. Name and Address of Facility PINCKNEY-SPANGLER FUNERAL HOME									
-310		23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. 524 - 8TH ST., N. E. WASH., D. C. 20002 Approximate intervel Between									
Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of):									
ficate be axecuted physician end as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceusa (Diseese or injury that initiated events									
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ing Physician: The lew requires that the different this certificate has been signed by the uneral director, page 2 should be detached	/ Physician/M	Pert II. Other significant conditions		23b. Did tobacco use contribute to the cause 1 Yes 2 No 3 Probably 4							
	Completed by			performed?		eutopsy findings ble prior to etion of cause th?					
							10	Yes 2 No	1 🗆 Ye	s 2 No	
	Be	25. Wes case referred to medical axaminer?	ath (Check only o								
	2	1 Yes 2□ No	Hospitel: 1 Inpatient		•		Home 5 Resi				
	lon	27. Menner of Death 1 Netural 5 Pending	(Month, Day Year) Injury Work?			28d. Describe	28d. Describe how injury occurred				
or Att	Certification:	2 Accident investigati 3 Suicide 6 Could not 4 Homicida determine	be 200 Place of lains	y - At homa, fa (Specify)	rm, street, factory, of		28f. Location (City or Ton	Street and Num vn, Stata)	ber or Rural Ro	outa Number,	
To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by	edical C										
To the within To the Comp	Me	29b. Signeryline and title oil portifier	4	29d. Date signed (Month, Day, Year) AUGUST 13, 1998							
(3)		30. Name and address of person wild convoled cause of death (item 23a) (Type, Print) MARIO F- GOLDE JR MD 3001 HOSPITAL PRIVE, CHEVERLY, MARYVAND 2078.									
St Regist	ate trar	31. Date filed (Month), Dey, Year) AUG 1 7 199	As	's Signature	5. ha	41					
ricgist	., Carl	MOR T 1 123	0		1	-					

AUG 171398 James S. Apriles

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 7 0 9 0

				Ce	rtificate of	Death		R	eg. No.			
	1. Decedent's Name (First, Middle, Last) Leone F. Sibert						2. Dete of Det Month					
Physician /Madical							7		Day 17	1998	6:35 AM	
/Medical Examiner	4e Fecility Neme (If not instituti	on, give street and n	um <i>ber)</i>	TE -		4b. City, To	own, or Loca	ugust ition of Deeth	4c. County			
LAMIIIIICI	Prince George	s Hospita	al			Temp.	le Hil	ls	Princ	ce Ge	orge's	
Funoral	5 Social Security Number 6 Sex 7 And (In vis. lest hirthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth								9 Rinthr	place (State or Foreign		
Funeral Director	235-14-4830	1□M 2ĂF	76	Yrs.	Months Deys	Hours	Min.	Sept. 6	1921	Braxt	on Co.W.V	
	Usuel Residence of Decedent							-				
show	10e. State 10b. Coun	У	10c. C	ity, Town or L	ocation					1	0d. Inside City Limit	
Man Man	Maryland Princ	e George's	s Ter	nple Hi	ills						1√ Yes 2□N	
with the Ma	10e. Street and Number		10f. Zip Code				10g. Citizen of Whet			ntry?		
death with the Maryland ms 23a or 28a-f show Lineal be notified at	3901 Triton Ct. 20748							USA				
aftar daath v v Hems 234 vere met	11. Meritel Status	12. Wes De	12. Wes Decedent Ever in U,S. 13			3. Wes Decedent of Hispenic Origin? (Sp			14. Rece - American Indien,		can Indien,	
flar daa	1 Never Married 2 Me		Armed Forces? 1 ☐ Yes 2 ☐ No		It Yes, specify Cuban, Mexican, Puerto			can, etc.)	Black, White, etc.			
	3.XWidowed 4 □ Divorce		ive		1 ☐ Yes 2 No Specify:				Specify	Specify: White		
72 hours natural; oleal Es		ent's Education		16a. Decedent's Usual Occupation					16b. Kind of Business/Industry		dustry	
led within 72 ho lygiena. Nor than "natura It, the Medical Completed	(Specify only high	(Specify only highest grede completed)		(Give kind of work done during most of wo life. DO NOT use retired)			st of working					
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id be fill be	Ernest H. Frame							J. Young				
공조늘법 는	19e. Informent's Name/Relation	achin (Time Brief)		40h 84ail	ing Address (Stree			0	City of Town	Ctoto Zir	Code)	
12 sh h and h and lis m											Coue)	
ss 1 and of Haalth item 27 other tr	Susan Diane Hu	yer/Daugni			Box 48 Da	ıllas,	West		11a 26U. 20c. Location -		Ctota	
Pagas nant of h	20a. Method of Disposition 1 ABurial 2 Cremetion	3 □Removal tron	. 01-1-	cemetery, cre	emetory or other pl	ace)	0/12					
parmit. Page Department of Important: If any Injury or otte	4 Donetion Other		Ced	lar Hi	ll Cemete	ery	8/2/	2/98	Suitlan	d, Md	l •	
parmit. Paga Departmant o mportant: If any Injury or	21. Signature of timeral Service	alicensee		G^2	2. Name end Addi	Kalas	Fune:	ral Hom	ne			
89 5 5 8	George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, Md. 20745											
	23a Part1 Inter the disease, shoot or heart failure. Li	or complications that	cal sed the dea	th. Do not en	nter the mode of dy	ing, such es	s cardiac or	respiretory err	rest,		Approximate	
Physician	and a contract results. Co	or only only cause on	dacir iirio.							- [Intervel Between Onset end Deeth	
/Medical	Immediate Cause (Final	6) / L		7		ter .	8 1.	10.0			
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cartificata	25. Wes case referred to medical 26. Piece of Deeth (Check only one)											
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Attending r death. octor: Afta by the funs ification	3 ☐ Suicide 6 ☐ Coule	not be						28t. Location (Street end Number or Rurel Route Number,				
within 24 hours after death. To the Funeral Director: After to completely filled in by the funeral Medical Certification:	4 Homicide deter	mined 200. Fied	building, etc. (Specify)					3901 Transcart 2074				
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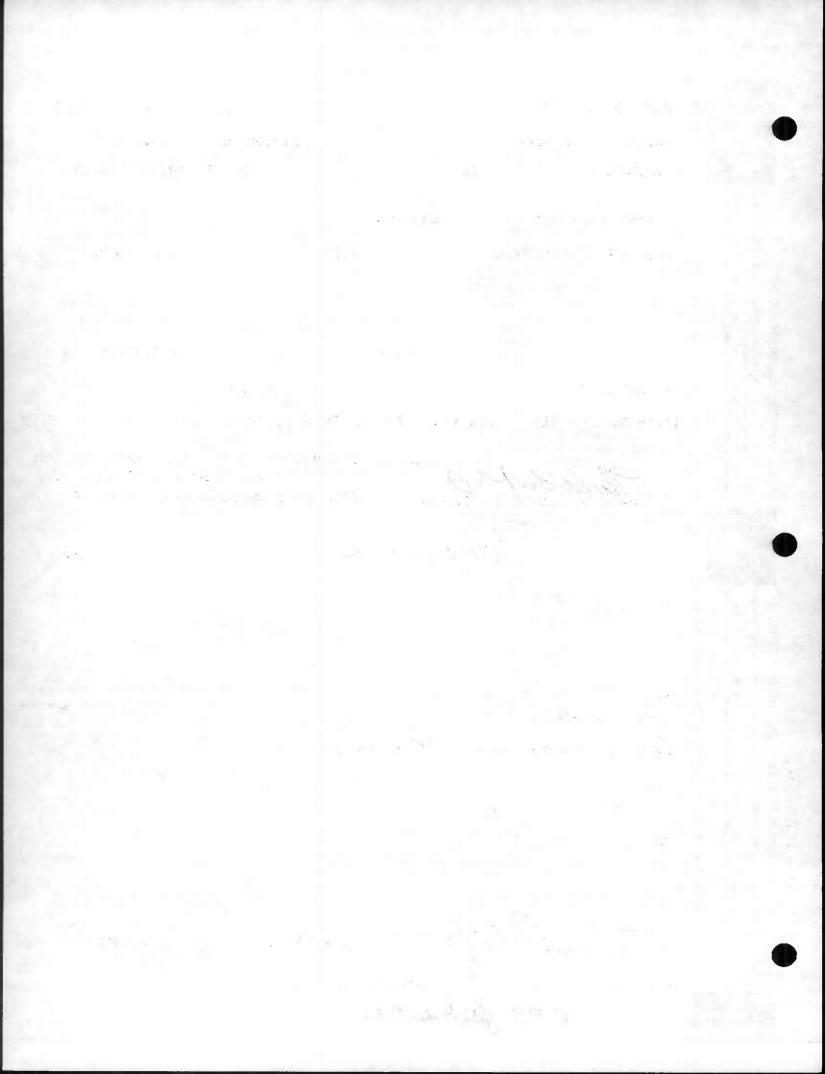
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		rtificate of Death	Rag. N	0.
ician	1. Decedant's Nema (First, Middla, Last) GLADYS SUBER			ay Yaar
dical niner	4a. Facility Nama (If not institution, giva streat and number) 9211 7 tua	of Land 4b. City, Town, or 1		4 98 2. AM
	Marine Health of Southern 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday, 5.77-84-1343 1 M 20 F 97 Yrs. Usual Rasidance of Dacedant	M D. Cluster If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	HD.	P.G. County
	10a. Stata 10b. County 10c. City, Town or L	ocation		10d. Insida City Limits
Ş	MD PRINCE GEORGES CLINTO	1		1 ☐ Yes 2 ☐ No
Director	10e. Street end Number	10f. Zip Coda	10g. C	itizan of Whet Country?
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Completed	15. Dacedant's Education 16a. Dece (Specify only highest grada complated) (Give	dant's Usual Occupetion kind of work dona during most of wor DO NOT usa ratired)	16b. I	KInd of Business/Industry
mpie	College (1-4015+)		Arrig	
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	Dunal 2 Dolamation o Differnoval from State		22, 98 WAS	SHINGTON, D.C.
	21. Signatura of Funaral Servica Licensaa 2:			ENKINS, INC.
	Delva & Sendono	716 KENNEDY ST.		,
edical Examiner	Immadiata Causa (Final disassa or condition rasulting in death) Sequentially list conditions, if any, leading to immadiata cause. Enter Undarlying Causa (Disassa or injury that initiated avants rasulting in death) Last Dua to (or as a consection of the conditions).	Heart Dise	rse	Minutes Years
Physician/Mec	d	ndarlying causa givan in Part I.	23b. Dld tobacc	o usa contribute to the cause of death?
by Ph	Azotemia		1 Tes	2 No 3 Probably Unknown
Completed b			24a. Was an auto parformed?	24b. Were autopsy findings available prior to completion of cause of daeth?
			1 □ Yas 2	1 Yas 2 No
o Be	25. Was casa referred to medical axaminer? 1 Yas 32 No	- Other: N	th (Check only one)	
ation: To	27. Mannar of Deeth 1 Natural 5 Panding (Month, Day Yaar) 2 Accidant Invastigation	3 DOA 4 Nursing H	ome 5 ☐ Residanca 28d. Dascribe how inju	
Certification:	3 ☐ Suicide 4 ☐ HomIcide 6 ☐ Could not be detarmined 28a. Placa of Injury - At homa, farm, str building, atc. (Specify)	aat, factory, offica	28f. Location (Street a City or Town, Stat	nd Number or Rural Routa Number, (a)
edical	29a. Cartifiar (Check only one) 1 Certifying Phyaicien: To tha bast of my knowledga, daatt 2 Medical Examiner: On tha basis of axamination end/or in-	occurred at tha tima, data and place, vastigetion, in my opinion, daath occur	and dua to tha causa(s red at tha tima, date an	s) end mannar as statad. d place, and dua to tha cause(s)
Mec	29b. Signature and title of cartifiar	29c. Licanse number	29d. De	ata signed (Month, Day, Year)
	30. Name and addrass of person who completed cause of death (Itam 23a) (Type,	y 20360	Hu	Sust 11, 1998
	The second of person with complaint causa of data (fiam 23a) (Type,	((4))	# 1	1 1 11
	Morton Elson 6525 R	planest Kd	208 11	Yallsville MI)

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	Certificate	e of Death	Reg.	No.	
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/Medical	JOHN EUGENE SEECH		August	6 1998	12:25 AM
Examiner	4a Facility Nama (If not institution, give street and number)	4b. City, Town, or L	ocation of Death	4c. County of Death	
	St. Mary's Hospital	Leonard		St. Mary	
Funeral Director	5. Social Security Number 232-03-1612 6. Sax 1 Months 7. Aga (In yrs. last birthday) 1 Months 7. Aga (In yrs. last birthday) Months	1 Yaar If Undar 24 Hrs. Days Hours Min.	(Month, Day, Ya	9. Birth Cou 912 Ken	placa (Stata or Foraign ntry) tucky
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within 72 hours after death with the Maryland end. Hash "retural", or items 23s or 28s-f show he Medical Evantive must be notified at he more marked by Funeral Director.	Maryland St. Mary's Mechanicsville				1⊠Yas 2□No
inter oean win me ma r items 23s or 28s-1s niner must be notified Funeral Director	10e. Streei and Number 10f. Zip 39398 Golden Beach Road 2	Code 0659		Citizan of What Cou nited Stat	
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deal	15. Dacedant's Education 16a. Decedant's Usua (Spacify only highast grada complatad) (Giva kind of wor	Occupation k dona during most of work a ratired)	king 161	b. Kind of Businass/Ir	ndustry
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Department of Heelth a Important: if item 27 is any injury or other tra once.	1 Men NOW (4)	Address of Facility Br 955 Hollywoo			
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nding physician end use as the burial-trensit n/Medical Examiner	Sequantially list conditions, if any, leading to immadiate cause. Enter Underlying Ceusa (Diseesa or Injury that initiated avants rasulting in death) Last b. Due to (or as a consequenca of): c. Dua to (or as a consequenca of):				
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been signed by the attending should be detached for use a letted by Physician/Me	,		1 □ Yes	2□ No 3□ Pro	obably Withnov
0 C/ C	Cerebroascula Acade	f	24a. Was an a parforme	d?	Vara autopsy findings vailable prior to ompletion of causa f death?
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entifica ector, Be	25. Was casa rafarred to madical axaminar?	26. Placa of Das	ath (Check only one)		
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in 24 hours after death. To 4 hours after death. Funeral Director: After to pletaly filled in by the funara edical Certification:	2 Accident invastigation 3 Sulcida 6 Could not be detarmined 28a. Placa of injury - At home, farm, streat, factory building, etc. (Specify)		28f. Location (Strae City or Town, S	at end Number or Ru Stete)	ral Routa Number,
the Hospital hin 24 hours a the Funeral I npletaly filled	29a. Cartifiar (Check only one) 1 Cartifying Physicien: To the best of my knowledge, death occurred 2 Medical Examiner: On the basis of examination end/or investigation, manner stated.				
To the To the Complet	29b. Suppliers and title of certifier 29c	Description of the control of the co	29d	E/6/9	Day, Year)
	30. Nema and address of person who complated causa of death (itam 23a) (Type, Print)			0	
0.1	DAVID C. ALLEN M.D. LEONARDTOW 31. Data filed (Month, Day, Year) 32. Registrar's Signatura	N,MD.20650			
State Registrar	ALIG 07 1998 Kui: Mayelyon Ranfall				

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State of Maryland / Department of Health and Mental Hygiene.

ociel Security Number 51-56-1448 11 51-56-1448 11 Sel Residence of Decedent Stete 10b. County Aryland St. Mary Aryland Arylan	HOSPITAL SX M 2 F 7. Ag M 2 F 7. Ag Y S IVE 12. Wes Decedent Armed Forces? 1 Yes, Give Yeer or Dates: ucation de completed) College (1-4or s	ge (In yrs. les. 39 10c. City, 1 Mech Ever in U.S.	Yrs. Town or Local anics V	If Under 1 Year Months Deys ation 7111e 10f. Zip Code 20659	Hispenic Origin? (Spen, Mexican, Puerto Specify:	8. Dete of Birn (Month, De July 2,	4c. County PRINCI PRINCI 1959 10g. Citizen of V United 14. Rac Blec Specify	9. Birthplece (Country) Marylar 10d. ins 10 Whet Country? States e - American Indek, White, etc.	stete or Foreign a.d. side City Limits □ Yes 2 ■ No
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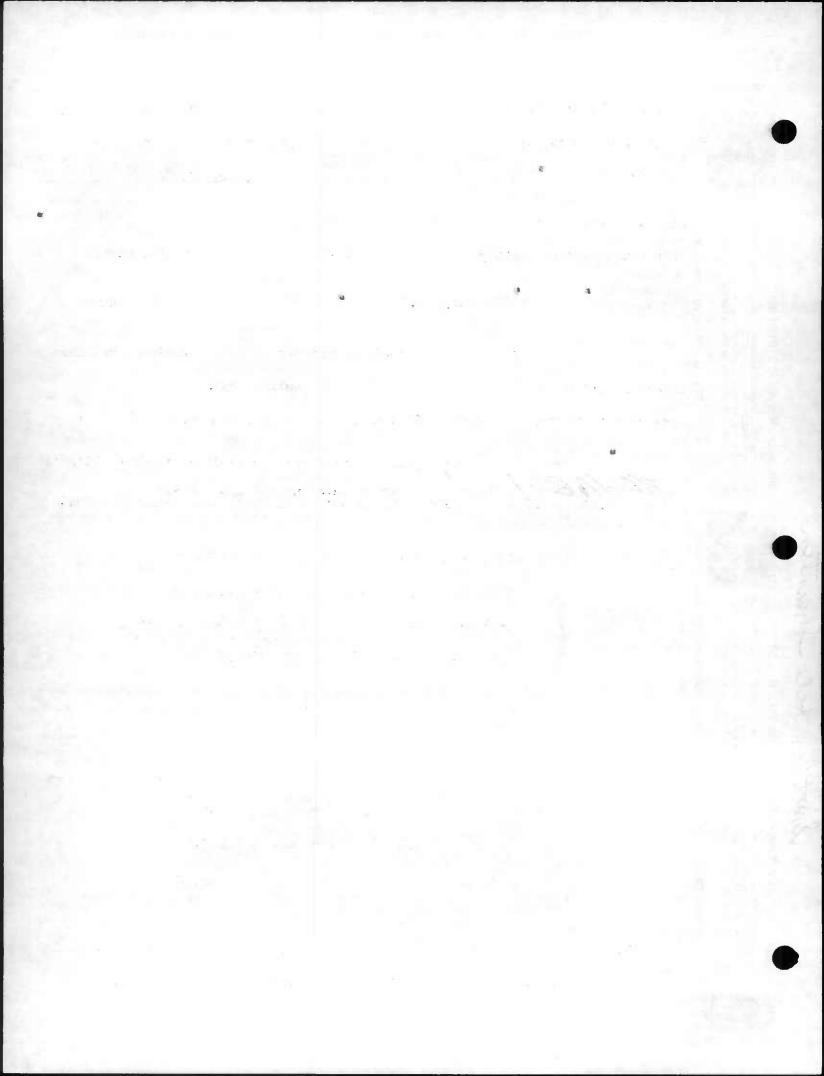
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	п	ST MAR	Y's HOSP	ITAL				LEONARI	OTOWN	ST	MARY	¹ S
ral or		Social Sacurity Nu 117-20-81	709 6. S		Age (In yrs. 72	last birthday) Yrs.	If Under 1 Y Months D		8. Dete of Birt	th y, Year)	9. Birtho	lace (State or Foreign try) . Chusetts
	-	a. State	Dacedant 10b. County		10c. Ci	ty, Town or Loc	ation				1	0d. Inside City Limits
tor	F.	lorida	Palm Bea	ach	De	1ray						1 ☐ Yes 2 ■ No
)irector	10	e. Street and Num	mber				10f. Zip Co			10g. Citizen of V	That Coun	try?
aic	29	998 South	h Federa	l Highway			334	183		United	State	es
d by Funeral Director		Meritel Status 1 Never Marrie 3 Widowed		12. Wes Decede Armed Force 1 Yes 2 [If Yes, Give Year or Date	s? ⊒No			of Hispanic Origin? (5 Cuban, Mexicen, Puer No Specify:	Specify Yes or No to Rican, etc.)	- 14. Reco	k, White,	
Completed		(Speci	15. Decedent's Edify only highest gra	ducation ade completed)		16e. Decede	ent's Usual O	ccupation one during most of wo atired)	rking	16b. Kind of Bu	siness/Ind	dustry
mpidm		Elementary/Secon		Collega (1-40	or 5+)					Busines	o Ma	chinos
		Father's Name /	First, Middle, Last,	6		меспап	iicai i	Ingineer	me (First, Middle,			cliffies
Be C		dward K.							Jaditz	Wallow Durnall	0)	
To	1		me/Ralationship (Type, Print)		19b. Mailing	Address (S	reat and Number or F		er. City or Town,	Stata, Zip	Coda)
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	20	e. Method of Disp				Place of Dispos cemetery, crem	ition (Name o	of r place)	Dete	20c. Location -	City or To	wn, State
			■ Cremation 3 ☐ 5 ☐ Other (Specif	Removal from Sta	(e	ropolit			3-22-98	Alexandr	ia.	Virginia
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once		Colla	91160	pr				eld Funera			2.00	22652
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	2	shock, or heer	ne disaase, or com nt failure. List only	one ceuse on each	n line.	tn. Do not ente	r the mode of	dying, such as cardia	c or respiratory e	rrest,	1	Approximate Intervel Between
cian											i	Onset end Death
ical iner	di	mediata Causa (F sease or condition	Final n	, Car	dio	- pu/	mm	ary ar	rest			
		sulting in death)			Dua to (or as a consaqu	uance of):	ary ar			1	
Examiner				b. Co.	rona	ery,	Arte	D.	-	,		
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****		equentially list con any, leading to im- luse. Enter Under	nditions, nmediata rlying Injury	Po	5+	or as a consequ	uenca of):	antin	lisp.	an F	717	
Ilcai		equentially list con any, leading to imi luse. Enter Under ausa (Disaasa or I at initiated avants sulting in death) L		c. <i>Po</i>	5 / Due to (c	or as a consequence or es e consequence	nam	, anting	ligp.	an Jr	7/	
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edic	Ca th re	at initiated avants		c. <i>Po</i>	Due to (c	or as a consequence of the conse	nam	anting	ligp.	an Jr	NT.	
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DHMH 16 Rev 6/95



Please

Please Type or Print	In Black Indelible Ink. Assure	All Coples Are Legib	ole.
State of Mar	yland / Department of Health and	Mental Hygiene	27095
	Certificate of Death	Reg. No.	
Decedent's Nama (First, Middle, Last)		2. Date of Death	3. Time of Death

Physician /Medica **Examine**

Funeral Director

pemit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiane. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other treumstic event, the Medical Examiner must be notified anones.

Baltimore, Maryland 21215-0020 To Be Completed Physician /Medical **Examiner** To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be datached for use as the burial-transit Medical Certification: To Be Completed by Physician/Medical Examir Division of Vital Records, P.O. Box 68760, 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and pisce, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifler

Joh	n Franc	cis	Scu	11y					August	26, 19	98	12:51 PM
4a Facility Nama (If not institution, giv	e street and numbe	r)	7-5			4b. City, To	wn, or Lo	ocation of Death			
41655	Church St	reet					Leona	rdto	wn	St.	Mary'	s
5. Social Security N 128-05-57	lumber 6. §	9X 7. A	age (In yrs. I. 84	ast birthday) Yrs.	If Under Months	Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Date October	h, Year) 17, 1913	9. Birthplac Country, Cana	e (State or Foreign da
Usual Residenca o	f Decedent 10b. County		100 Ch	. Town or La	- antino						1404	to alide Ola di Imiae
Maryland	St. Mar	y's		, Town or Lo Leonar		n					100.	Inside City Limits 1 ☐ Yes XX No
10e. Street and Nu	mber				10f. Zip	Coda				10g. Citizen of	What Country	?
41655 C	hurch Str	eet			21	0650				U.S.	Α.	
11. Marital Status 1 □ Never Marr 3 □ Widowad	ied 2 Married 4 Divorced	12. Was Decedar Armed Forces 1 ☐ Yes 2 A If Yes, Give Yaar or Datas	?] No				dispanic Ori an, Mexicar Specify:		ecify Yes or No- Rican, etc.)	14. Rad Bla Specif	ce - American ck, White, atc	
/Sner	15. Decedent's Ed	ducation		16a. Dece	dent's Usu	al Occup	oation	t of work	rina	16b. Kind of B	usiness/Indus	itry
Elementary/Second		College (1-4o	r 5+)	life.	Carpe		du <i>ring</i> mos d) T	(O) WOIN	ang .	Unio	n	
17. Father's Name	(First, Middle, Last) J. Scully				14				e (First, Middle, t Harri		na)	
19a. Informant's N	ame/Relationship (Type, Print)		19b. Maili	ng Address	s (Street	and Number	er or Rur	ral Route Numbe	or, City or Town,	, State, Zip Co	ode)
20a. Method of Dis 1X Burial 2		Removal from State	CE	P.C lace of Disposemetery, cres	ositi <i>on (N</i> ar ma <i>tory</i> or c	me of other pla	ce)		town, M Date 8/29/98	D 20650 20c. Location		
23a. Part1/Enter t shock, or hea Immediate Cause disease or condition resulting in death)	rt tailure. List only (Final	plications/that causone cause on each	line.	P n. Do not ent	.O. B	ox 2	270, L	eona	Funera ardtown, or respiratory ar	Maryla	and 206	pproximate terval Batwaan neet and Death
Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events resulting in death)	injury	b		as a consec		4) iše	ees				
Part II. Other signif	ficant conditions o	ontributing to death	but not resu	ılting in the u	inderlying o	ause gir	ven in Part I		23b. Dld 1	obacco use co	ontribute to th	e csuse of desth?
Cach	erfia -	nutril	inces	2					10	Yes 20 No	3 Probat	oly 4 Unknown
Sas to	o Esophi	igal !	refle	uf De	sias	e			24a. Was perfo	an autopsy mad?	availa comp of dea	autopsy findings abla prior to letion of cause ath? 'es 2 \sum No
25. Was case refer							26. Place	of Deat	th (Check only o	ne)		
examiner?	No	Hospital: 1 Inpat	tient 2 🗆 I	ER/Outpatier	nt 3 D0	Ott	ner: 4 Nu	ursing Ho	ome 5 Resid	lenca 6 🗆 Oth	ner (Specify)	
27. Manner of Deat 1 Natural 2 Accident	h 5 Pending Investigation	28a. Date of In (Month, D		28b. Time o Injury		28c. Inju Wo 1 □	ryat rk? ∣Yes 2□	No	28d. Describe h	now Injury occur	rred	
3 ☐ Suicide 4 ☐ Homlcide	6 Could not be determined	28e. Place of In	njury - At ho	me, farm, sti	reet, factor	y, offica			28f. Location (S City or Tox		ber or Rural R	loute Number,

10 State Registrar

31. Date filed (Month, Day, Year) AUG 2 6 1998

John Fenwick, MD

32. Ragistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

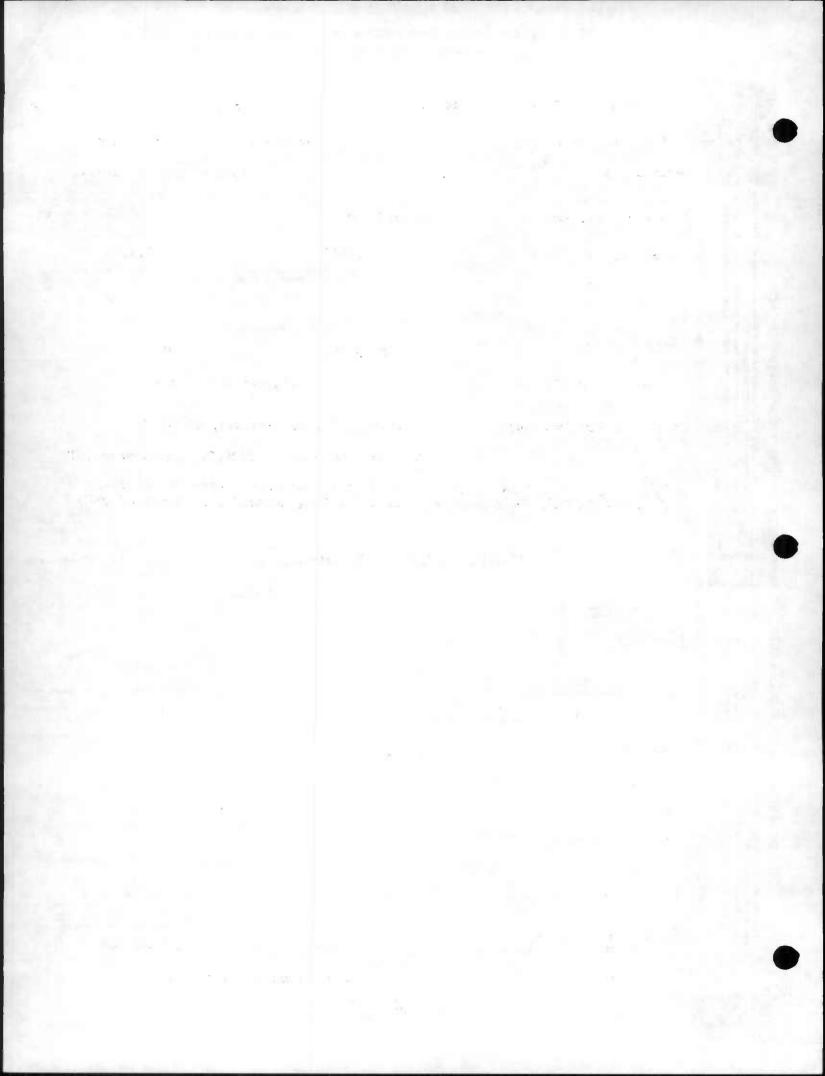
ooks

29c. Licanse number

Leonardtown, Maryland 20650

29d. Date signed (Month, Day, Year)

8/24/98



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 27096

					C	ertificate of	Death	F	leg. No.		
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Physician /Modical		lliam 1	1	58	yr	nour			Dey 199		2145
/Medical Examiner	4n Coniti	ity Neme (If not institution, g	ive street end number)		-) - '		4b. City, Town, or Lo	ALL	4c. County		2143
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Funeral	5. Social	SHADY GROV Security Number 6.	E ADVENTI	ST I	ast birtho	av) if Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, De)		9. Birthpl	ece (Stete or Fore
Funeral Director			1XM 2□ F		79 Yrs	Months Days	Hours Min.			Coun	try)
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or oth	ME	Montgo	merv	Po	ole	sville					Yes 2□1
vith the Mar t or 284-f el be notified Director	100 Stee	et end Number	2			10f. Zip Code			log. Citizen of W	het Coun	to/2
1 0 0 O		16 Elgin R	626				20837		_	S.A.	•
23 m	1//							" N N			
n 72 hours after death with the Marylend "naturel", or itema 23a or 28a-f ehow ad cal Examiner must be notified at leted by Funeral Director	11. Marit	al Stetus	12. Was Decedent Armed Forcas?		5.	 Was Decedent of F If Yas, specify Cub 	n, Mexicen, Puerto	Ricen, atc.)	Bleck	e - Americ k, White,	
and and		Never Married 21 Married	If Yes, Give	No		1 ☐ Yes 2 🛣 No	Specify:		Specify:	whi	ite
irel', o	3 🗆 🗎	Widowed 4 □ Divorced	Year or Dates:	WW	[]					*****	
		15. Decedent's (Specify only highast g	Educetion grade completed)		16e. De	ecedent's Usuel Occup live kind of work done le. DO NOT use retire	ation during most of work	ing	16b. Kind of Bu	sinass/Inc	dustry
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Agian to the control of the control		8			th	ermostat	control	ler f	ionicg.	CO 1	Joara L
tiel Hygin d other event,		er's Neme (First, Middle, Las	st)				18. Mother's Name	a (First, Middla,	Maiden Sumem	Θ)	
	Wil	lliam P. Se	ymour				Caro	lyn Mc	ssburg		
12 should the end Mani 7 is marked traumatic	19e. Info	orment's Name/Reletionship	(Type, Print)		19b. N	ailing Address (Street	end Number or Run	A Routa Numbe	r, City or Town,	Stete, Zip	Code)
4430	Ve	era Seymour	wife		177	16 Elgin	Rd. Poc	lesvil	le, MD	208	337
- 7 5 5		hod of Disposition		20b. P	leca of D	sposition (Neme of		Data	20c. Location -	City or To	wn, Stete
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permit. Pag Department Important: If any injury o	21. Sign	eture of Funerel Service Lic	ensee			22. Neme end Addre	Funeral	Homo			
10280	1	Well CIA	il						Rarne	SVI	lle MD
	23e. Pe	rt1. Enter the diseese, or coock, or heart failure. List only	mplications thet caused	the deeth	. Do not	enter the mode of Jyi	ng, such es cerdiec	or respiretory er	rest,		Approximete Interval Between
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cele be executed physician end sthe buniel-transit	Sequent if eny, le	ially list conditions, eding to immediate		Due to (o	r es e cor	sequence of):					. 1
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physicie is the bu	resulting	eted events in daeth) Last		Qua to (or	as a con	sequance of):					(
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Se de d									111001	CO	mpletion of ceuse
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ata hes been signe page 2 should be d	25. Was	cese referred to medical	Hospital: a /			O	26. Plece of Deet	101		of	death?
his certificate hes been signed if director, page 2 should be d	25. Was exen	riner? Yes 2 No	Hospital:		ER/Outpo		ner: 4 Nursing Ho	1 □ N th (Check only o	ne) lence 6 □Othe	of 1 [er (Specif	death? Yes 2000
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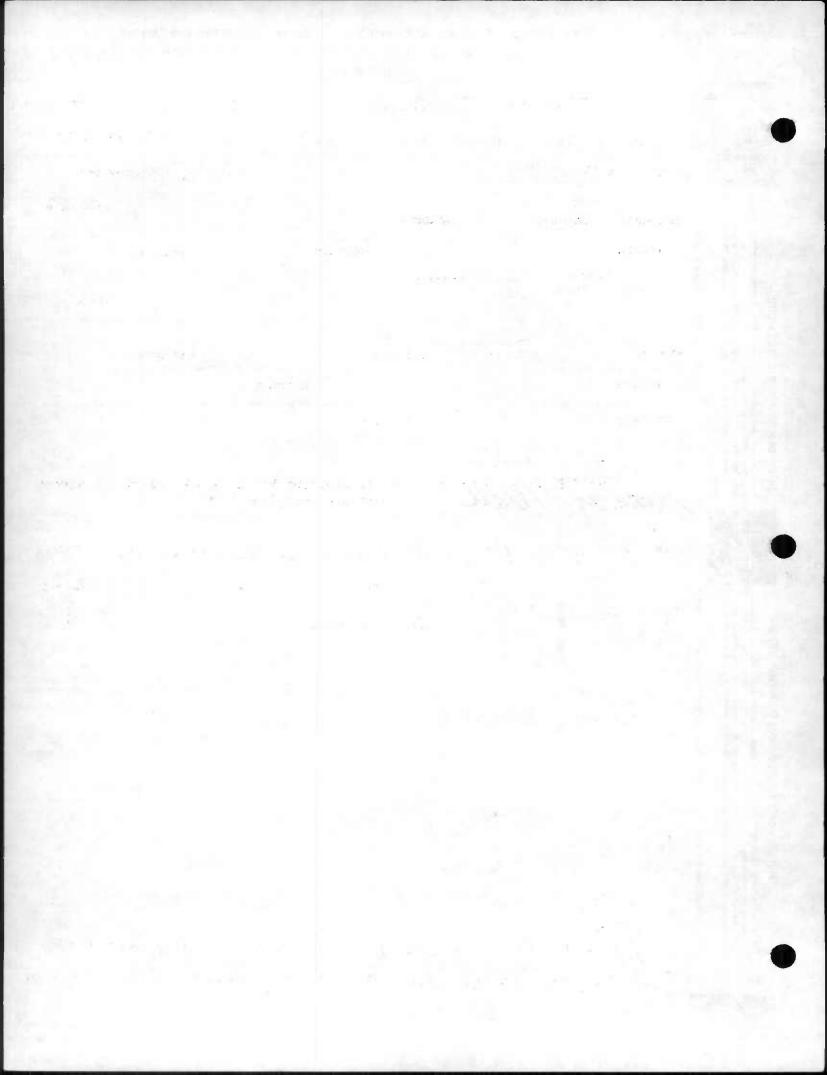
State of Maryland / Department of Health and Mental Hygiene

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aminer	4e Facility Name (If not institution BONSECO		mber)	AL			46. City, To BALT		ation of Deeth			e City
eral tor	5. Social Sacurity Number 242-30-5524	6. Sex 1 ☐ M 2 ☑ F	7. Age (In yrs. 55	last birthda Yrs.	y) If Under Months	1 Yaar Days	If Undar Hours	Min.	8. Date of Birtl (Month, Dey July 25	, Yeer) 5, 1943	9. Birthr Cour unkn	oleca (Stata or Foraig ntry) OWN
	Usual Residence of Decedent		10.00									
ctor	unknown unkr	nown		y, Town or known	Location							unknown UYes 2 No
al Director	10e. Street end Number unknown				10f. Zip unl	Code Cnow	n			10g. Citizen of V unknow		ntry?
by Funeral	11. Marital Status unknown 1 Navar Marriad 2 Marri 3 Widowed 4 Divorced	12. Was Dec Armed Fo ed 1 Yes If Yas, Gi Year or D	ve	S. 10	3. Was Deced if Yes, spec		lispenic Ori en, Mexicer Specify:	gin? (Spec n, Puerto R	cify Yes or No- lican, etc.)	14. Rac Ble Specify	ck, White,	
Be Completed	15. Decedent (Specify only highes	's Education		16a. Dec	edent's Usue	ol Occup	ation	t of workin	0	16b. Kind of B	usiness/in	dustry
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-	19e. Informent's Neme/Reletionsh unknown	nip (Type, Print)			elling Address	(Street	and Numbe	er or Rurel	Route Numbe	r, City or Town	Stete, Zij	Code)
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	21. Signature of Huneral Service L NOTIAL O	wade.	Directo		22. Name an State Baltim					W. Balt	imor	e Street
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Dy Physician	Part il. Other significent condition		leath but not res	ulting in the	underlying c	euse giv	ven in Pert i	to the state of th	23b. Did t	20		o the cause of death bably 4 ☐ Unknow
Completed p										en eutopsy rmed?	av	ere eutopsy findings vailable prior to empletion of ceuse deeth?
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To	exeminer?	Hospitel:	Inpatient 2	ER/Outpet	ient 3□ DC	OA Oth	er: 4 Nu	ursing Hom	e 5 Resid	ience 6 🗆 Ott	ner (Speci	fy)
	27. Manner of Deeth Netural 5 Pending Accident investig		of Injury oth, Dey Year)	28b. Time Injur		8c. Injur Wor 1 □	yet rk? Yes 2□		8d. Describe h	now injury occur	red	
ertific	3 ☐ Sulcide 6 ☐ Could n 4 ☐ Homicide determi	ned 286, Piece	e of Injury - At he ling, etc. (Specif	ome, ferm,	street, factor	, office		2	8f. Location (S City or Tow		ber or Rur	el Route Number,
edical Certification:	29a. Certifier (Check only one) Certifying 2 Medical E	Phyetcian: To the Examiner: On the b	e best of my kno esis of exemine oner stated.	wiedge, de tion end/or	ath occurred Investigation	et the tir in my o	me, dete en pinion, des	nd plece, ea	nd due to the d d et the time,	ceuse(s) end m date end plece,	enner es : end due !	steted. to the cause(s)
Me	29b. Signature and talk of certifier		/	200			e number 425	-10		29d. Date signed Aug -	od (Month, 26 TK	Dey, Year) 1998
	30. Name end eddress of person v		se of deeth (Item		e, Print)	82	-1. N.	EUT	AWST	, # 4	107	1998 MD21201

Registrar

SEP



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Tima of Deeth Month Dey **Physician** MARGARET TARRANT AUGUST 6, 1998 3:59PM /Medical 4b. City, Town, or Location of Deeth 4a Fecility Neme (If not institution, giva street and number) 4c. County of Deeth Examiner SOUTHERN MARYLAND HOSPITAL PRINCE GEORGE'S CLINTON If Undar 24 Hrs If Under 1 Year 5. Social Sacurity Number 7. Age (In yrs. lest birthday) 8. Data of Birth (Month, Dev. Year) Birthplace (State or Foreign Country) **Funeral** Months Deys Hours 1 M 2 F 80 Yrs. Director Unk JUNE 14, 1918 VIRGINIA Usuel Residence of Decedant with the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic evant, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD PG Clinton 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 20735 USA 9211 Stuart Lane death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 200 No If Yes, Give Yaer or Detes: Wes Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Ricen, atc.) 14. Rece - American Indian. 11. Marital Status Bleck, White, etc. filed within 72 hours after 1 □ Naver Married 2 □ Married 1 Yes 2 No BLACK Specify: þ 3 Widowad 4 Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest greda completed) el Hygiene. College (1-4or 5+) Elementery/Secondary (0-12) 12th CLERK NATIONAL SECURITY AGENCY 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fethar's Neme (First, Middle, Last) Peges 1 and 2 should be lant of Health end Mentel I h end Mentei h CHARLES CLEMONS NANIE BRADFORD 19b. Meiling Addrass (Straat end Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Typa, Print) item 27 l 4007 SHEPHARD BRENTWOOD , MARYLAND CARRIE CHAPMAN / NIECE 20722 other 20e. Method of Disposition
1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Dete 20c. Locetion - City or Town, Stete Depertment of Important: If it any injury or c LINCOLN MEMORIAL CEMETERY 8-18-98 SUITLAND, MD 4 ☐ Donation 5 ☐ Othar (Specify) 22. Name end Address of Facility MARSHALL'S FUNERAL HOME OF MD 21. Signature of Funerel Service Licenses 4308 SUITLAND RD. SUITLAND, MD ant. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, hock, or heart failure. List only ona ceuse on each line. Approximate Interval Batwaen Onset and Deeth **Physician** /Medical Immediate Ceuse (Finel disease or condition rasulting in daath) Examiner Examine requires that the death certificate be executed physician end the burial-transit Sequentially list conditions, if eny, leading to immadiate ceuse. Enter Underlying Causa (Disaasa or injury that initiated events resulting in deeth) Lest Box 68760. Physician/Medical 88 attending 20 P.0. signed by the a 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown þ Records, 24b. Wara eutopsy findings available prior to should should 24a. Was an autopsy Completed completion of ceuse of deeth? The law has e 2 certificate 1 Yes ZUN 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: director, Be 25. Was cese referred to medical exeminer? 26. Place of Death (Check only ona) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this funerai 27. Menner of Deeth 28e. Date of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28b. Time of 28c. Injury et Work? 5 Panding invastigation Aftar 1 Netural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 Could not be 3 Suicide Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 1 Cartifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end manner stated. edicai 29a. Certifier pietaly (Check only one) To the I within 2 To the I complet 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier 29c. Licensa number 30. Nama end eddrass of person who ted ceuse of de 23e) (Type, Print)

Registrar

State

31. Dete filed (Month, Day, Year)

AUG 1 8 1998

32. Registrer's Signature

					State of M	arylan		artment of	Health and N		iene		7099
			1. Decedent's Name							2. Dete of Dea	th	V	3. Time of Death
	Physicia /Medic	_	ESTH	16 12 H.	THUIZ	PE		10		Month S	Day	9 98	16:25PM
	Examin		4a Facility Name (#	not institution, give	street and number))			4b. City, Town, or L	ocation of Death	4c. County		
				GEORGE GE					CHEVERLY		PRINCE	GEOR	RGE
L	Funeral Director		5. Social Security Nu 241-34-38. Usual Residence of	33	7. A	ge (In yrs.	last birthday) Yrs.	If Under 1 Yes Months Day		8. Dete of Birth (Month, Day JUN. 27	, 1913		D, NC
	hand hand		10a. State	10b. County	201	10c. City	y, Town or Lo	cation				10	d. Inside City Limits
	Men II	to	MARYLAND	PRINCE G	EORGE	CA	PITOL	HEIGHTS					1X Yes 2 No
	128 H	Directo	10e. Street and Num	iber		1		10f. Zip Code		1	0g. Citizen of V	Vhat Countr	y?
	23a c		515 DR	UM AVENUE				20743	3		u. s.	A.	
20	72 hours effer deeth with the Maryland natural, or thems 23s or 28s/ show lical Examinar must be notified at	by Funaral	11. Marital Status 1 Never Marrie 3 V Widowed	2112	12. Wes Decedent Armed Forces 1 Tes 2 If Yes, Give Year or Dates:	?		Vas Decedent of Yes, specify Cu	Hispanic Origin? (Sp ban, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	Blec	e - America k, White, et	ic.
5-0020	n 72 hours netural',		7	15. Decedent's Edu			16a Deced	lent's Usuel Occ	upation		16b. Kind of Bu		
21215	yen.	Completed	(Special Special Speci	fy only highest grad idary (0-12)	e completed) College (1-4or	5+)	(Give	kind of work don DO NOT use retii DOMESTIO	e during most of work red)	sing	PRIVA		,
Maryland	a 1 and 2 should be filed within Health end Mental Hygiene. Iem 27 ie marked other than other traumatic event, trau	To Be C	17. Father's Name (I		HARR1.	S			18. Mother's Nam		Maiden Surnam DZART	(e)	
	s 1 end 2 sho f Health end ftem 27 le m other traum		19a. Informant's National IRENE PEA					RUM AVE	et and Number or Rui CAP I TÖL				Code)
Baltimore	Page Int: If I			osition Cremetion 3 F	Removal from State	0	emetery, cren	sition (Name of netory or other p		Date /22/98	20c. Location -		
Balt	permit. Pag Depertment Important: I any injury o		21. Signature of Fun	negat Sprince Lighten	islo	1			ress of Fecility -SPANGLER H ST., N.			201	202
			23a. Pert1. Enter the	e disease, or comp	mons thet ceuse	d the death	n. Do not ente	or the mode of d	ying, such as cardiac	or respiratory arr	est,		Approximate intervet Between
	Physician												Onset and Death
	/Medical Examiner		Immediate Cause (F disease or condition resulting in death)	4	MAL	Due to (o	MAN ras e conseq	uence of):	ENTRI (VLAR	1010		3 DAYS
	be executed	Examiner	Sequentially list con-	ditions,	DILA-	Due to (o	r es a conseq	MAIS!	o MYOP	ATHY	, / \ ((\arg)	1	1 year
	yalole ne bur	Cal	Sequentially list con- if any, leading to im- cause. Enter Under Cause (Disease or in that initiated events resulting in death) Li	njury	ACUT		PES es a consequ		TORY	INSM	FFKIL	= rucy	13Days
Box	esth certificat attending phy i for usa es th	Physician/Med		ι,	1								
, P.O.	requires that the deeth certifica een signed by the attending ph hould be detached for use as the	by Physic	Part II. Other eignific	extus	ntributing to death b	^	ulting in the ur	1 NSW	offilsons	1 D V	ea 2 No		the cause of death?
Records,	aw requirates to been signated by 2 should by	Completed b	Deh	y dra	tion.		- 10			24a. Wes e perfor	n eutopsy ned?	evai	e autopsy lindings lable prior to pletion of cause seth?
E .	The law ata has b page 2 s	Š								10 Y	es 20 No	10	Yes 2□ No
/Ita	ysicien: The s certificata director, pag	8	25. Was case referre	ed to medical					26. Place of Dee	th (Check only or	e)		
of Vital	0 0	2	1□ Yes 2 🕽 🖈	lo I	lospital: 1X Inpati	ent 2 🗆	ER/Outpatien	3 DOA C	Other: 4 Nursing He	ome 5 Reside	ence 6 Oth	er (Specify)	
Division	Attending Phir death. actor: After th by the funeral	sation:	27. Manner of Death 1 ☑ Natural 2 ☐ Accident	5 Pending investigation	28a. Date of Inju (Month, Da	ay Year)	28b. Time of Injury		ury at ork? □ Yes 2 □ No	28d. Describe h	ow injury occurr	red	
DIVIS	ital or Attend ins after death ral Diractor: / lied in by tha	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of In building, et			eet, fectory, offic	θ	28f. Location (S City or Town		er or Rural	Route Number,
	To the Hospital of within 24 hours aff To the Funeral Di complately filled in	Medical	one)	2 Medical Examin	nician: To the best ner: On the basis o and manner st	examinat	wledge, death ion and/or inv	estigation, in my	time, date end place, opinion, deeth occur	red et the time, d	ate end plece, a	and due to	the cause(s)
	within to the Comple	Σ	29b. Signature and to	. 1		1			nse number		9d. Date signed	d (Month, D	eay, Year)
9	0	1	MY	-d N	1. Meh	板	WD	D	2736	6	0/13	7/01	(

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MUG 1 8 1998

ARVIND M. MEHTA MD FIDD Balt: MOR 31. Date filed (Month, Day, Year) 2. Registrar's Signature

Are # 509, Collège Park MD 20440

\$16:81998 James H. Jank

98-4720-027 98-175

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 27 | () ()

tony teasy	37			Certifica	te of Death	7	Reg	ı. No.	1.0	100
Dhualaian	1. Decedent's Name (First, Mic			12.0			te of Deeth	Day	Year	3. Time of Deeth
Physician /Medical		Tony Tea	astey				UST	13,19		2:18P.M.
Examiner	4a Facility Name (If not institu	tion, give street and number	91)			own, or Location	of Death	4c. County		
	ROCKY GORGE PA		A // 4 4-	at decid lifeting		urel	to of Dist	HOWAR		(0)
Funeral Director	5. Social Security Number unavailable	6. Sex 7.	Age (In yrs. last bii 4 7	Yrs. Month		Min. 8. Da (M. 7	te of Birth onth, Day, 1	(ear)	Country	ce (State or Foreign y) :on Va
pua *	Usual Rasidenca of Decedent 10a. Stete 10b. Cour	ntv _	10c. City, Tow	n or Location					100	d. Inside City Limits
ith the Marylar or 28a-f show as notified all	Md Ho	oward		urel						1□Yes 2☐No
23 a	10e. Street and Number	9506 Howard	d Ave		2.0723			US.	A	
Urs after	3 □ Widowed 4 🖺 🕏 Vord	If Von Cive	s? Stylo		adent of Hispanic O ecify Cuban, Mexico 2017 o Specify		es or No- etc.)		e - Americar ck, White, et Whit	c.
72 hours naturel.	15. Deced	ent's Education hest grade completed)	16a	Decedent's Us	uel Occupation work done during mo use retired)	est of working	16	6b. Kind of Bu	usiness/Indu	stry
	Elementary/Secondary (0-12		or 5+)	Plum	use retired) ber	of or working	- 4	Com	merio	cal
E C C C C C C C C C C C C C C C C C C C	17. Fether's Name (First, Midd	le. Last)			18. Moti	her's Name (First	, Middle, Ma	aiden Suman	ne)	
ylanc build be fi Mental H srked ott atic ever		John	W Teasl	У		Ма	rgie	F. H	arris	3
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offer offer offer	20a. Mathod of Disposition 1 Burial Accomation 4 Donation 5 Other		20b. Place of cometa Ches	f Disposition (Nay, crematory of a peake	other place) Cremate	ory 8/1	7/98	Belt	City or Tow	n, Stete Le MD
Baltimo permit. Page Department: If Important: If any injury or anse.	21. Signature of Furneral Servi	- Harington Mas	un/	22. Name	and Address of Fec	Sterlir	g Fu	neral	Serv	vice
Physician /Medical Examiner	Immediata Causa (Final disease or condition resulting in death)		OWNIM Due to (or as a	1						nierval Between Onset and Death
L Box 68760, death certificate be axecuted a attending physicien and ad for use as the burial-transit sician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated avents resulting in death) Last	c	Due to (or es a			F'				
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DHMH 16 Rev 6/95

CIPPETT, GARNETT ARCHIE

Registrar **DHMH 16 Rev 6/95**

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BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, nage 5 should be detached for use as the hurial-transit narming Panes 1 2 3 should
be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.										
	1. DECEDENT'S NAME (First, Middle, Last)	Williams		2. DATE OF DEATH DAY			3. TIME OF DEATH 7:05 A.M				
	4. SOCIAL SECURITY NUMBER 5. SEX 1 SEM 2 F 6. AGE (In yrs. last birthday) 7 A YRS. 6. AGE (In yrs. last birthday) 1 SEM 2 F 7 A YRS. 6. AGE (In yrs. last birthday) 1 SEM 2 F 7 A YRS. 6. AGE (In yrs. last birthday) 1 SEM 2 F 7 A YRS. 6. AGE (In yrs. last birthday) 1 SEM 2 F 7 A YRS. 7 DATE OF BIRTH (Month, Day, Ybar) OI - 15 - 26 8. BIRTHPLACE (State or Foreign Country) VA										
TOR	98. FACILITY NAME (If not inelitution give etreet and number) 99. CITY, TOWN OR LOCATION OF DEATH 90. COUNTY OF DEATH										
DIRECTOR		meiset		nes Qualtel	2		10d. INSIDE CITY LIMITS? 1 YES 2 TO NO				
FUNERAL	100. STREET AND NUMBER		D	101. ZIP CODE		10g. CITIZEN OF V	YHAT COUNTRY?				
В	11. MARITAL STATUS 1 Never Married 2 Merried 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 💆 YES IF YES, GIVE WAR OR I	2 NO	13. WAS DECENDENT OF HISPAL If yes, specify Cuban, Mexico 1 TYES 2 KLNO Specif	in, Puerto Ricen, etc.)	r No.— 14. RACE Black Speci	E - American Indien, k, White, etc.				
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	JCATION e completed) College (1-4 or 5+)	We. Do NOT use ret	done during most of working fred.)	Somet.	NESS/INDUSTRY	unty				
	17. FATHER'S NAME (First, Middle, Last)	Se	MT:NAC!	16. MOTHER'S NA	ME (First, Middle, Maiden St		tation				
TO BE	19a. INFORMANT'S NAME (Type/Print)	ms or.	196. MAILING ADD	RESS (Street and Number of Rural	RD Dame		tu, MD21821				
1	20e. METHOD OF DISPOSITION 1 M Burlai 2 Cremetion 3 Rem 4 Donation 5 Other (Specify)	20	PLACE AND DATE OF DI	sposition (Name of	DATE 20c. LOCA	TION — City or To					
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY ATTHOOGUE Ward Tuncial Home										
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, ahock, or heart fellure. List only one ceuse on each line. IMMEDIATE CAUSE (Final											
	IMMEDIATE CAUSE (Final disease or condition resulting in death) a. ACUTE MYOCAPDIAL (NFAP CTON) DUE TO (OR AS A CONSEQUENCE OF):										
ATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERIVING										
RTIFICATION	CAUSE (Disease or Injury that initiated events resulting in death) LAST										
AL CE	PART II. Other significent condition	ns contributing to death	out not resulting in th	e underlying cause given in	Part I. 24s. WAS AN AI		WERE AUTOPSY FINDINGS				
EDIC	LIVER FAILURE, ALCOHOUSM PERFORMED? 1 YES 2 MINO										
Σ	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN										
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 Inpetiant 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)										
PHY	27. MANNER OF DEATH	URY OCCURED									
BY	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 8 Could not be	Number or Rural Route Number,									
	4 Homicide determined	building, atc. (Spe		281. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
COMPLETED	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) and manner as stated. MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER OF SIGNATURE AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)											
										T.P. Kanchan	z. MD 3
	31. DATE FILED (Month, Day, Year) ALIC 9 4 1000	32. REGISTRAR'S SIGN	IATURE 4				- 3.1				

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

					Certific	ate of	Death	F	leg. No.			
Physicia /Medica	al		ee Wa	11 ac	2			2. Date of Dea Month	Day 21	Yaar 9 8	3. Time of Deeth 12:50pm	
Examine	∍r	4a. Facility Neme (If not institution, give Lot 62 Matth	ew Dr.					r Location of Deeth	4c. County Queer		2010	
Funerai Director	5. Social Security Number 213-08-5484 6. Sax 1 Marth Security Number 10 Marth Security Number 10 Marth Security Number 10 Marth Security Number 10 Marth Security Number Secu							Yeer)	9. Birth	plece (Steta or Foraigntry) ryland		
pue 🔉		Usual Residence of Decedent 10e. State 10b. County	1	Oc. City, Tow	n or t ocation						10d. Insida City Limit	
with the Marylen a or 28a-f show be notified at	ō	MD Queen									12 Yes 2 □ N	
28a	rec	10e. Street end Numbar	Allile S	Crum		Zip Code			Og. Citlzen of V	Whet Cou	ntry?	
23a o		Lot 62 Matth	ew Dr.			21628	3		U.S.A.		,	
urs a	Completed by Funeral Director	11. Maritai Status 1 ☑Never Marriad 2 ☐ Marriad 3 ☐ Widowed 4 ☐ Divorcad	12. Was Dacedent Ev Armed Forces? 1 Yes 2 XNo If Yes, Giva Yeer or Detes:	er in U,S.	13. Was De	cedent of I- specify Cub		Specify Yes or No- rto Rican, etc.)	14. Rac Blac			
- 20		15. Decedent's Education (Specify only highast grade completed) Elementery/Secondery (0-12) College (1-4or 5+)					pation during most of we d)	16b. Kind of Business/Industry				
モエセミ !		9 17. Fether's Name (First, Middle, Last))		Stu	dent	18. Mother's Ne	eme (First, Middle,	Meiden Surnem	ne)		
d be ental	Io Be	Robin Wallace	2				Terri			,		
should ind Men i marke umatic		19e. Informent's Name/Relationship (19b	. Mailing Addr	ess (Street		Rurel Route Number		Stete, Zip	Code)	
1 end 2: Health er em 27 is other trau		Terri Wallace	(mother		.O. Bo			mpton,				
		20a. Method of Disposition 1X3 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donetlon 5 ☐ Other (Specif.	Leunoval Itom Stele	20b. Pleca of cematar	Disposition (in the property of the property o	Veme of or other place	ce)		20c. Location - Crump	City or To		
permit. Page Department of Important: If any injury or once.		21. Signature of Funerel Service Licer	200 MOO5	10	Galer Box 2	end Addre	ss of Fecility Ineral Galena	Home of	Steph	en 1	L. Schae	
Physician /Medicai Examiner	ner	Immediate Causa (Final disease or condition resulting in death)) Sarce		, meta	static			3 years	
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ate h page	5							1 □ Y	as ZENo	1 [Yes 2□ No	
certificate rector, pag		25. Wes case referred to medical exeminer?						ath (Check only or	Θ)			
S E E	- -	1 ☐ Yes 2 ☑ No 27. Manner of Deeth	Hospital: 1 Inpatient	2 ER/Out		DOA Oth	4 Li Nursing	Home 50 Reside			y)	
is elected ath. Is offer death. In Director: After this certification. Cartification. To Be	Calloll	1 Naturel 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	M				y et k? Yes 2 □ No	28d. Describe how injury occurred				
al Dir		4 ☐ Homicide determined 286. Pleas of Injury - At home, farm, street, fectory, office building, etc. (Specify)						281. Location (Street end Number or Rurel Route Number, City or Town, Stete) the time, dete end place, end due to the cause(s) and manner as stated.				
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within 2 To the comple		29b. Signatura and title of certifier	and mariner stotes		:	29c. Licans	e number	2	9d. Date signed	d (Month,	Dey, Yaar)	
3	-	Dum 10	Los in	9		DI	D17036 8/21/9 a Are Chestatron Md.			78		
		30. Name and address of person who of Susun K. Ross	m.D. 5/	(Item 23e) (shing t	ba K	Fre Che	estation	md.	216	20	
State Registrar		31. Date filed (Month, Day, Year)	32. Registrer's	Signeture	1							

DHMH 16 Rev 6/95

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death 05: 12 PM **Physician** BARBARA WILLIAMS AUGUST /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GEORGES PHNCE GEORGES PRINCE HOSPITAL CENTER CHEVERLY If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Dale of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1 M 200 F Hours 227-52-0786 58 Director September 11, 1939 Virginia Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 X Yes 2 No Prince George's Directo Maryland Capitol Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20743 U.S.A. 126 Maryland Park Drive se filed within 72 hours after death all Hygiene. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Merital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Merried 2 ☑ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Domestic Worker Private 11th other traumatic avant, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) t 1 and 2 should be fill Health and Mental H tam 27 is marked off George Hunt Gladys Hunt 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 20743 19e. Informent's Neme/Reletionship (Type, Print) permit. Pages 1 and 2: Department of Health as Important: if itsm 27 is any injury or other trau Matthew D. Williams/Husband 126 Maryland Park Drive, Capitol Heights, MD 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 08/20 1 X Burial 2 ☐ Cremetion 3 ☐ Removel from State Maryland Veterans Cemetery Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 1998 22. Name end Address of Fecility
J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licensee 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest,

Approximate Approximete Intervel Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical . HYPERTENSIVE ARTERIOSCUEPOTIC CARDIOVASCULAR PISEASE Examiner Due to (or as e consequence of) Examiner physician and s the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated assets) Due to (or es e consequence of): Box 68760. Physician/Medical that initieted events resulting in death) Last Due to (or es e consequence of): 8 23b. Did tobacco use contribute to the cause of death? Records, P.O. Part II. Other significant conditions contributing to death but not resulting In the underlying cause given in Part I. 1 | Yes 2 | No 3 Probably 4 Unknown Ď 24a. Wes an autopsy performed? 24b. Were eutopsy findings available prior lo Completed completion of cause of death? 21 NO 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one)

Division of Vital

Attending

ò

Be 10 this funeral Certification: After a after des.

1 Yes 2 No

27. Manner of Death

1 Neturat

2 Accident

3 ☐ Suicide

29a. Certifier (Check only one)

4 ☐ Homicide

To the Hospital o within 24 hours at To the Funeral Di completaly tilled in edical

31. Date filed (Month, Day, Year) State Registrar

29b. Signature 30. Name and address of person who comp MAKIO F. GOLLE

5 Pending investigation

6 ☐ Could not be

AUG 1 8 1998

ted cause of death (Item 23a) (Type, Print) MD 3001 32 Registrar's Signature

1 Inpatient 2 ER/Outpatient 3 DOA

Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28b. Time of

28a. Date of Injury (Month, Day Year)

DRIVE,

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as stated.

Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end manner stated.

29c. License number

1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

AUGUST

29d. Date signed (Month, Day, Year)

CHEVERLY, MARYLAND 20.785

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 7

	1 Decederals New / Process	die Leet		Certificate of	Death	1	Reg. No.		A Provide office	
ysician Medical	1. Decedent's Neme (First, Mid	M.	W A05			2. Dete of Dee Month AV G	Dey	Year 999	3. Time of Death	
miner	4e. Fecility Neme (If not institut				4b. City, Town, or Lo	ocation of Death	4c. County	of Death		
	Howard Count			Williams A Wasse	Columbi			ward		
ral tor	5. Sociel Security Number 6. Sex 7. Age (in yr 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7			thdey) if Under 1 Year Months Deys	8. Dete of Birth (Month, Day Nov. 1	v. Year)	9. Birthp Coun Nort	lece (Stete or Foreign try) h Carolina		
	Usual Residence of Decedent 10e. Stete 10b. Coun	У	10c. City, Town	n or Location				1	Od. Inside City Limits	
5	1√ 1 1 vy 1									
Director	Mary Land Howard Columbia 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country?								trv?	
0	8715-11 Haysh	ed Lane		la Ai	21045	į	Unii	Pad S	tates	
by Funerai	11. Meritei Stetus 11 Never Married 2 Ma 3 Widowed 4 Divorce	12. Wes Dec	2. No	13. Wes Decedent of Fif Yes, specify Cubin 1 Yes 2 No		ecify Yes or No- Rican, etc.)		a - America k, White, o Afr	an Indien,	
Be Completed	15. Decede (Specify only high Elementary/Secondery (0-12) 5 t h	est grade completed) College (Decedent's Usuei Occup (Give kind of work done life. DO NOT use retired	during most of work d)	ing	16b. Kind of Bu	usiness/inc	dustry	
ပိ	17. Fether's Neme (First, Middle	/ Ast)		Launde	18. Mother's Name	a /First Middle		civat	e	
Be	Walter Wade	.,			.oonioi s italiii		a Barfie	-		
To	19e. Informent's Neme/Reletion			Meiling Address (Street		al Route Numbe	r, City or Town,	Stete, Zip	Code)	
once.	Angelo Wade	/ Son		6517 Greenmo	ount Dr.,	Elkride	ge, MD 2	21075		
	20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 4 ☐ Donetion 5 ☐ Other		Stete cemeter	Disposition (Neme of y, cremetory or other plead In Memorial	1	Dete / 21 / 98	20c. Location -		and second	
DUCE.	21. Signature of Funeral Service		2	22. Neme end Addre	ss of Fecility	tewart H			TID	
<u> </u>	23a. Par 1 Enter the disease, shown or heart feilure. Li	Slewo	4,111	4001 Ber	nning Rd.	, N.E. V	Wash., I).C.	20019	
ণ ছ leted by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underfyling Cause (Disease or Injury that initiated events resulting in death) Last		Due to (or es e o	consequence of):	Infanch	1111		İ	> 10 1/22	
Completed by Physician/Me							23b. Did tobacco use contribute to the cause of death?			
y Ph	Metastatic Uterine concer.						1 Yes 2 No 3 Probably 4			
pleted b	Me tastatic breast concer 240. Wes en eutopsy performed?						eva	ore eutopsy findings alleble prior to appletion of cause death?		
Con						1 🗆 Y	es 2 No	1 🗆	Yes 2□ No	
Be	25. Was case referred to medic examiner?				26. Place of Deetl	h (Check only or	ne)	-		
Certification: To	1 Yes 2 No 27. Manner of Deeth 1 Netural 5 Pend 2 Accident inves	28e. Dete- ing (Mon- igation	npatient 2 ER/Out of Injury th, Dey Year) 28b. T	Ime of 28c. Injury Wor	4 LI Nursing no	ome 5 Resid 28d. Describe h			")	
Certific	3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Foundation of City or Town, Stete)							er or Rura	l Route Number,	
Medical (29e. Certifier (Check only one) 1 Certify 2 Medica	f Examiner: On the be	best of my knowledge, ests of examination and ner stated.	deeth occurred et the tir l/or investigation, in my o	ne, dete end plece, pinion, deeth occurr	end due to the ored at the time, o	eeuse(s) end me dete end placa,	enner es st and due to	ated. the cause(s)	
Medical Certification: To Be Com	29b. Signeture end title of certif	er		29c. Licens			29d. Dete signe		Day, Year)	
	30. Neme and eddress of perso	who completed caus			0573	14	-17-	98		
	Jon Minfind	, MD	11065 hi	#14 Patur		way Ca	lowbia	MD	2044.	
State	31. Dete filed (Month, Dey, Yea AUG 2 0		egistrer's Signeture	9. Sport	-					

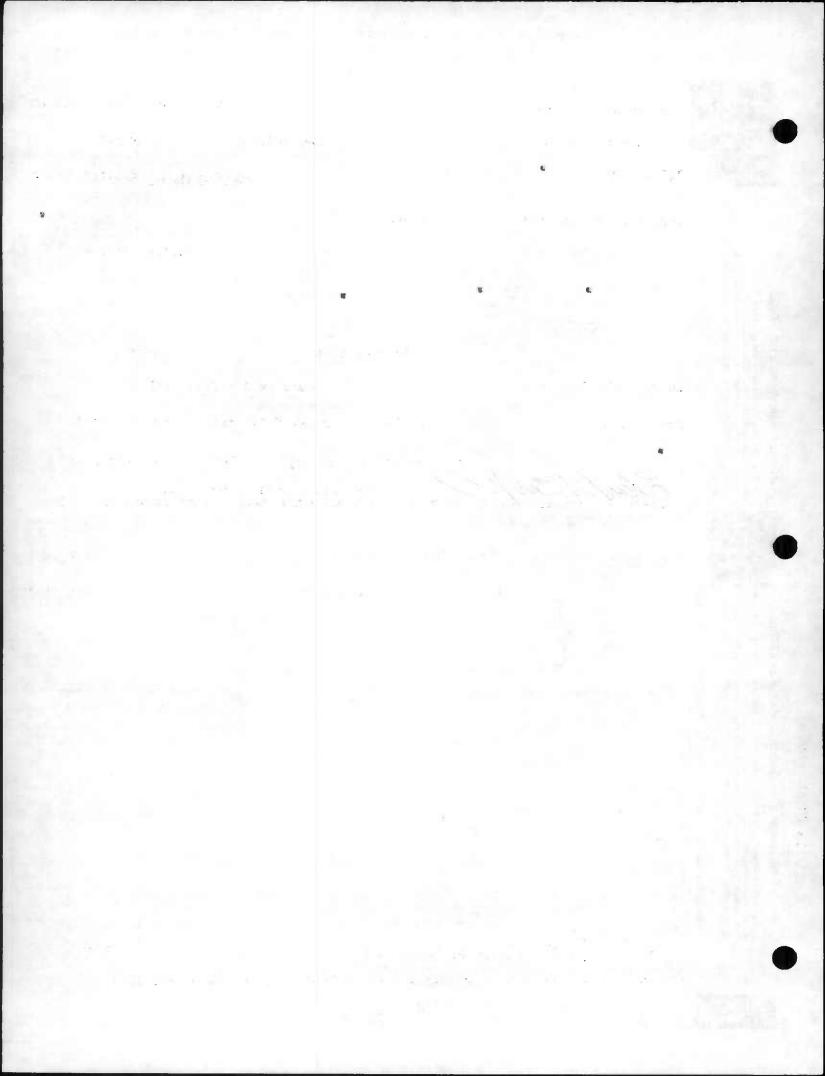
THE RESERVE

State of Maryland / Department of Health and Mental Hygiene

				Ce	rtificate	of I	Death			Reg. No.				
	1. Decedent's Nama (First, Middle,	ast)		100					2. Data of De		Voor	3. Time of Death		
Physician	Charles Robert W	bool				August	I'6	1998	4:24 AM					
* /Medical Examiner	4a Facility Nama (If not Institution, g		ber)			1	b. City, To	own, or Lo	ocation of Deat	h 4c. County	of Death			
Examiner	St. Mary's Hospi	tal					Leona	rdto	พา	St.	Mary'	S		
Furianal			. Aga (In yrs. las	t birthday)	If Undar 1		If Under	24 Hrs.				laca (Stata or Foreign		
Funeral Director	215-62-9061	1■M 2□F	42	Yrs.	Months I	Days	Hours	Min.	(Month, Di	ay, Year)	Coun Ralti	more, MD		
	Usuat Rasidence of Dacedent		72					1	Lecencer	11, 1955	Darer	more, rib		
Mo s	10a. State 10b. County		10c. City, 7	Town or Lo	cation						10	Od. Inside City Limits		
Mary	Maryland St. Ma	rv's	Ca1	iforn	nia							1 ☐ Yes 2 ■ No		
h the Marylen r 28a-f ahow rrollfad	10e. Street and Number				10f. Zip C	ode				10g. Citizen of \	What Coun	trv?		
with of D	23049 Acorn Lane				206					United				
d 21215-0020 Illed within 72 hours effer death with the Maryland Hygiene. Hygiene. Inter than "natural", or items 23a or 28a-f show not, the Madisal Examinar Intertal parcell add. Completed by Funeral Director	11. Marital Status		dent Ever in U,S.	13			ispanic Or	rigin? (Sp.	ecify Yas or No		e - Americ			
Her d	1 Never Marriad 2 Married	Armed Ford	ces?	10.	f Yes, specify	Cuba	an, Mexica	n, Puarto	Rican, etc.)		ck, White,			
20 soft	3 □ Widowed 4 □ Divorced	tf Yes, Give			1 ☐ Yes 2	No	Specify	:		Specify	· Wh	ite		
21215-0020 d within 72 hours of giene. then 'netural', or then 'netura	15. Decedent's			16a Dece	dent's Usual (Decun	ation			16b Kind of B				
I 21215-00 led within 72 holygiene. The Medical Int. The Medical Completed	(Specify only highest	rade completed)	rade completed) (Give I life. D			done o	during mos	st of work	ing	16b. Kind of Business/Industry		,		
within then then	Etementery/Secondery (0-12)	College (1-	4or 5+)		k Off					Bank	ing			
nd 212 e filed with al Hygiene. other ther vent, man	17, Fathar's Name (First, Middle, La	st)		Dai	III OIII			er's Nam	e (First, Middle	, Maiden Suman				
land libe files entel Hyg ked othe ic event, o Be C	Charles Abell Wo									ossbach				
T T T				don salis	- Address (1	Dinat					State Zin	Code		
Maryland nd 2 should be file lith and Mentel Hy 77 Is marked othe traumatic event.	19a. Informant's Name/Relationship (Type, Print) Debra E. Wood, Wife 19b. Maiting Address (Street and Number or 23049 Acorn Lane, Ca.													
Health	Debra E. Wood,	WI			ACOTI esition (Nama matory or other		-	Call	Date					
Baltimore, M permit. Peges 1 end 2 Department of Health e Important: if item 27 if any Injury or other tra once.	20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3		etery	1	/19/98	20c. Location -	City of 10	WII, Stata						
Baltimoperant: Peg Department: Important: it any Injury o	4 ☐ Donation 5 ☐ Other (Spe	Mary	land											
Balt permit. Departi Importa	21. Signature of Uneral Service (Centre) 22. Name and Address of Facility Brinsfield Funeral Home P													
W 82 E 8 8	Edward N. Brin	Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650												
	23a. Pert1. Enter the disease, or co	mplications that cal	used the death.								11, 111	Approximate		
Physician	shock, or heart failure. List only one cause on each line.											Interval Between Onsat and Death		
/Medical	Immadiata Cause (Finat disease or condition resulting in death) Respiratory failure Due to (or as a consequence of):										1	, d		
Examiner	disease or condition resulting in death)	a	espira	1019	Tui	1 41	6				19	Sout medo		
Per time is	Breeze State State													
68760, ficete be executed physician end is the buriel-transit edical Examiner		b. M+	etas fati		419	(al	neer				19	SONT 6 MMH		
ords, P.O. Box 68760, requires thet the death certificete be executed een signed by the ettending physician end hould be deteched for use as the buriel-transit eted by Physician/Medical Examir	Sequantially list conditions, if any, teading to immediate cause. Enter Underlying		Due to (or a	Due to (or as a consequence of):										
68760, ificete be en physician as the burie	Cause. Enter Underlying Ceuse (Disease or Injury that Initiated events	C									1			
phys s the	resulting in deeth) Last		Dua to (or as	s a consec	juence of):									
oentific ding p		d												
S, P.O. Box (see that the death certifies that the death certified by the ettending be deteched for use a by Physician/M.														
O state of the sta	Part II. Other significant conditions contributing to death but not resulting to the underlying cause given in Part I.									tobacco usa co	ntributa to	the cause of death?		
P.O net the day the deteched									10	Yes 200 No	3 Prol	bably 4 Unknown		
Vital Records, aldan: The law requires the centificate has been signed rector, page 2 should be descompleted by											045 111			
cord require been sig should b										s an autopsy omed?	ava	ere eutopsy findings ailable prior to		
Receian response by the second											of	mpletion of cause death?		
al Record The law require sate has been si page 2 should Completed	A REPUBLIC OF								10	Yes 2 No	10	Yes 2□ No		
Vital I	25. Was case referred to medical		8-7-				26. Plac	e of Deat	h (Check only	one)				
of Vita Physician: this certific and director,	examiner? 1 ☐ Yes 2 ☒No	Hospital:	patient 2 EF	VOutpatie	nt 3 DOA	Oth	OF.			idence 6 □Oth	ner (Specifi	v)		
0 5 53	27. Manner of Deeth	28e. Dete of (Month		8b. Time o		. Injur Wor				how injury occur		<u> </u>		
Vision Attending I or death. ector: After by the fune iffication	1 Netural 5 Pending 2 Accident investigat		, Day Year)	Injury	М		1k? Yes 2.⊑]No						
isio trandi death. ctor: A y the fu	3 ☐ Suicide 6 ☐ Could not	be and Disco	office			28f. Location (Street and Number or Rural Route Number,								
Division of or attanding Physelect Geath. Jin by the funeral diffication: To entification: To	4 Homicide determine	building	g, etc. (Specify)				City or Town, State)							
Division of To the Hospital or Attanding P within 24 hours eiter death. To the Funeral Director: After to ompletely filled in by the funeral Medical Certification:	20a Cartifles 150 Cartifidas Divisiona To the heat of my knowledge death applying at the time date and due to the squee(s) and manner as stated													
Hos 24 ho Fun stely	29a. Certifier 1½ Certifying Physicfen: To the best of my knowtedge, death occurred at the time, date and place, and due to the cause(s) and manner as steled. (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and manner stated.													
To the within To the comple											Day, Year)			
T W S	255. Olgholald and till	wh					004	4		08 17	1100	3		
	(()				MDI	2	004	1		00/14	1100	18		
	30. Name and address of person with MOHAMMAD A. RAHMA	o completed cause	of death (Item 2	3a) (Type,	Print)	DIC	AT OF	TID *	IOT T TITLO	00 100 0	0606			
		11 FI.D.	LHILLI	J. B.	LAN ME	DIC	AL C	IK. I	10LLYWO	OD,MD. 2	.0636			
State	31. Date fited (Month, Day, Year)		gistrar's Signatur		1									
Registrar	AUG 1 8 1998	3 pen	va /	7.	Spork	2								

DHMH 16 Ray 6/95

CHARLES ROBERT WOOD



Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

							Ce	rtificat	e of	Death	,	g. No.			
	Physicia	n	1. Decedent's Nem			7					2. Dete of Deeth Month	Dey	Yeer	3. Time of Deel	
	/Medic		A. F. 199 No. 11	Elbert						4b. City, Town, or Lo	August	19,		9:55 P.	Μ.
	Examine	er													
1—			5. Social Security N				lest birthday)	If Under	1 Year	Frederi If Under 24 Hrs.			deric		neion
	Funeral Director		214-28-09 Usuel Residence of	81	1⊠M 2□F	68	Yrs.	Months	Deys	Hours Min.	8. Date of Birth (Month, Dey, March 29	,1930		lece (Stete or For try) yland	ory r
arviend	ahow	2	10a. Stete	10b. County			ty, Town or Lo						1	0d. Inside City Lin	
5	288-1	Director	West Va.	Jeffers	on	Har	pers F	erry 10f. Zip	Code		10	10g. Citizen of Whet Country?			
with	0 8														
eath	rne 20	Funeral	358 Carri	age Driv	12. Was Decede	ent Ever in U	l.S. 13.	-	425 dent of F	lispanic Origin? (Sp en, Mexican, Puerto		United 14. Rao		es an Indien,	
020 urs after	al', or iter	þ		ed 2⊠ Married 4 □ Divorced	Armed Force 1 Yes 21 If Yes, Give Year or Dete	No No				en, Mexican, Puerto Specify:	Ricen, etc.)	Specify	ck, White, v: Wh.i		
5-0	Pages 1 and 2 should be filed nearly of Health and Annala Hybrid II filed II for a rearrant covern, and of the traumatic event, To Be C	ted	(6000	15. Decedent's E	ducation		16a. Dece	dent's Usua	ol Occup	petion during most of work	ing 1	6b. Kind of Bu			
21215-0020 d within 72 hours af		omple	Etementery/Second 11	ndery (0-12)	College (1-4	or 5+)	life.	DO NOT us	se retire	of Ways	ang .	County	ernment		
DQ e			17. Fether's Neme ((First, Middle, Last)					18. Mother's Name	e (First, Middle, M	leiden Sumem	(0)		
Maryland		0	Elbert We	1sh Sr.						Beatrice	Burdett	е			
lar 2 sho			19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stetch											Code)	
č			M. Eloise Welsh/ Wife 358 Carriage Drive, Harpers Ferry West Va. 25 20e. Method of Disposition (Neme of Dete 20c. Location - City or Town, Stete												
altimore,					Removal from Ste	1	cemetery, cre	metory or o	ther ple	ce)	Dete 2	Oc. Location -	City or To	wn, Stete	
tim Pa				5 Other (Special		Mor				ist Cemet	ery8/24	Damas	cus,	Maryland	l
Bal	permit. Pa Departmer Important: any Injury phose.		21. Signature of Fu	neral Service Lice	Nolesus	th	01	in L.	Mo	lesworth Road, D				0872	
	100		23a. Pert1. Enter the	ne diseese, or com	p cetions thet ceu	sed the deel	th. Do not en	ter the mod	e of dyl	ng, such as cardiec	or respiretory erre	st,	and 2	Approximete Intervel Between	
PI	Physician		one on the same	is tand or allow or by										Onset end Death	1
4	Medical xaminer	Immediate Cause (Fine) disease or condition resulting in death) Pue to (or es a consequence of): MULTIPLE MYELOMA											4 days)	
		_	Immediate Cause (Finel disease or condition resulting in deeth) Due to (or es a consequence of): AULT DOLE MYSSIF PATON FAILURE 4 /2 we												
pet	nsit	Examiner			b. 1902				A					TOYEA	48
68760, ificate be executed	physician and the buriel-transit	Exal	Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events Due to (or es e consequence of): Due to (or es e consequence of):												
68760, ficate be ex	physician the burie	edical	Cause (Disease or thet initieted events	injury	C	Due to /c	or as e consec	mence of).				-	-		
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Box ath cert	attandin for use	2			d								1		
D. E	ed fo	SICI	Pert II, Other signifi	Icant conditions	contributing to deat	h but not res	ulting in the u	nderlying c	euse giv	ven in Part I.	23b. Dld tol	oacco uaa co	ntributa t	the cause of de	ath?
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of Vital Records, P.O. Box	been sign	Completed by Physician/M	HYPER	CALCEM	ICE PHAL	MAL	16NAX	icy			24e. Wes er perform	eutopsy ed?	ev	ere eutopsy findin eilable prior to mpletion of ceuse deeth?	
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	is certificate ha director, page	Bec	25. Wes case refer	red to medical						26. Plece of Deat	h (Check only one	/			
f V	direc	0	exeminer?	No	Hospital:	atient 2	ER/Outpatie	nt 3 DC	Oth Oth	ner: 4 Nursing Ho	ome 5 Reside	nce 6 □Oth	er (Specil	(y)	
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Division		Sertific	3 Suicide 4 Homicide	6 Could not be determined	289. PIGCG OT	I Injury - At home, farm, street, fectory, office , etc. (Specify) 28f. Location (Street end Number or Rurel Route for City or Town, State)						al Route Number,			
• Hospit	within 24 hours efter To the Funeral Director Completely filled in	edicai	29e. Certifier (Check only one)	Certifying Pt	nysician: To the be miner: On the besis and menner	s of examina	owledge, deet ation end/or in	h occurred vestigetion	et the ti	me, date end plece, ppinion, death occur	end due to the ce red et the time, da	use(s) and me ite end place,	enner es s end due t	teted. o the cause(s)	
Toth	Withir To th	M	29b. Signature artif	title of certifier	6			290		se number	29	d. Date signe	d (Month,	Day, Year)	
			1 to	in Elly	most "	D			D	31761		8/20	198		
			30. Name end addre		completed cause of		m 23e) (Type,	Print)	VEN)	ny st.	PENERIC	K MI	0 2	1701	
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DHMH 16 Rav 6/95



2 1 1998

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month **Physician** 1^{Day} Roscoe WILES 1998 McClellan August 6:15 pm /Medical 4b. City, Town, or Location of Death 4a. Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner Northampton Manor Nursing Center Frederick Frederick 5. Social Sacurity Number If Undar 1 Yaar If Undar 24 Hrs. 7. Aga (In yrs. last birthday) 8. Data of Birth Month, Day, Year Jan 1924 9. Birthplaca (Stata or Foreign Country)
Maryland **Funeral** Days OCM 20 F 74 Yrs. Director 218-14-7327 Usual Residanca of Decedent the Maryland 10a. Stata 10b County 10c. City, Town or Location r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 10d. Inside City Limits Director Maryland 1 ☐ Yas 2 ☐ No Frederick Thurmont 10f. Zip Coda 10e. Street and Number 10g. Citizan of Whet Country? filed within 72 hours efter death with 6409 Mountaindale Road U.S.A. 21788 Funeral 12. Was Decedant Evar In U,S. Armed Forcas? 1 □ Yas 2 □ No If Yas, Giva Yaar or Dalesknown 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian, Black, Whita, atc. 11 Marital Status 1 Navar Married 2 Married 1 ☐ Yas 2 No Specify: þ Specify: White 3 Widowad 4 Divorced Completed 15. Decedent's Education 16a. Decedant's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry (Spacify only highast grada complated) Hygiene. Elamantary/Secondary (0-12) College (1-4or 5+) 10 Shipping and receiving clerk Parts supply company marked other traumatic event. 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) Be Pages 1 end 2 should be innent of Health end Mental Innt: If item 27 is marked of Lee McClellan Wiles Effie Catherine Smith 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Steta, Zip Coda) Department of Health elimportant: if item 27 is any in ury or other training. Sharon C. Young/Daughter 10930 Putman Road, Thurmont, MD 21788 20a. Mathod of Disposition 20b. Placa of Disposition (Nama of 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Smithsburg Crematory Aug. 18, 1998 Smithsburg, MD 21. Signature of Funeral Service License 22. Nama and Addrass of Facility
Keeney & Basford P.A. Funeral Home 100021 106 East Church St, Frederick, Maryland 21701 23a. Part1. Enter the disease, or complication that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cell is on aach line. Approximata Intarval Batwo **Physician** fmmediata Ceuse (Final disaasa or condition rasulting in daath) /Medical Lung Years Examiner and Sequentially list conditions, if eny, laading to immadiata causa. Entar Undarlying Ceuse (Disaasa or Injury that initieted evants resulting in death) Last Dua to (or as a consequence of): physician Physician/Medical the Dua to (or as a consequance of): Part ff. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? been signed by t should be detect Yes 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings availabla prior to complation of causa of daath? Completed 24a. Was an autopsy parformed? certificate 1 ☐ Yas 2 ☐ No 25. Was casa rafarred to medical Be 26. Placa of Death (Check only one) 2 1 Yas 2 No Other: Nursing Homa 5 Assidanca 6 Othar (Specify) 1 Inpatiant 2 ER/Outpatient 3 DOA this funeral Certification: 27. Mennar of Death 28a. Date of Injury (Month, Dev Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? After Netural 2 Accident 5 Panding 1 Tes 2 No invastigation 3 Suicida 6 Could not ba 28e. Placa of Injury - At home, farm, street, factory, office building, atc. (Spacify) Location (Street end Number or Rural Route Number, City or Town, Stata) 4 Homicide

The lew requires that the death certificate be executed Box 68760. P.O. I Division of Vital Records, or Attending Physician: death. efter death Director: / d in by the f To the Hospital within 24 hours e To the Funeral C completely filled Hospital

21215-0020

Baltimore, Maryland

29b. Signatura and titla of certifiar 29c. Licanse number Tolim D51610

29d. Data signed (Month, Day, Year) August 18, 1998

30. Nama and addrass of person who completed causa of daath (Itam 23a) (Type, Print)

Michael A. Tolino, M.D., 1475 Taney Ave, Suite 204, Frederick MD 21702

Cartifying Physician: To the best of my knowledge, daath occurred at tha tima, date end place, and dua to tha ceuse(s) end mannar as stated.

2 Madical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at tha tima, data and place, and dua to the ceuse(s) and manner stated.

State Registrar

Medical

29a. Certifian

31. Date filed (Month, Day, Yaar) AUG 2 0 1998



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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 09, Deuk M. Yoo Aug. 1998 6:00AM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) Examiner Glen Burnie Mariner of Glen Burnie Anne Arundel Co. If Under 24 Hrs. Hours Min. 5. Social Security Number 6. Sex 7. Aga (In yrs. lest birthday) If Under 1 Year Birthplace (State or Foraign Country) **Funeral** 1□M 2□F Months Days 89 218-94-3974 Director Korea 6-21-09 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or itama 23a or 28a-f ahow the Medical Examiner must be notified at Md. 1 Ves 2 No Anne Arundel Severn Direct 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 8211 Clearwater Court 21144 Korean death 14. Race - Amarican Indian, Black, Whita, etc. 12. Was Decedent Ever in U,S. 13. Was Decedent of Hispanic Orlgin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) Armed Forces? 1 ☐ Yes 2√2No 1 ☐ Naver Married 2 ☑ Married Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: Specify: Korean P 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) N/A 12 Unemployed 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fathar's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental Hant: If Nem 27 is marked oth lury or other traumatic avan Be Jung Joon Yoo Jung Won Ahn 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) Dong W. Yoo (Son) 8217 Bambridge Ct.. Pasadena, Md. 21122 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) Date 20c. Location - City or Town, State 1 ☐ Burlal 2 ☐ Cremation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any Injury or Wash. Cemetery 8-13-98 Adelphi, Md. 22. Name and Address of Facility Phillip Bell Fun. Ser. ■ Fuderal Service Licensee 4902 Stan Haven St. , Temple Hills, Md. 23a. Part 1. Enter the dispuse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Daath **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner certificate be executed ician and burial-trans Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical Due to (or as a consequence of): the esn ö Part fl. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? the 3 1 Yas 2 No 3 Probably 4 Unknown been signed t should be det p 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy Completed performad? page 2 1 Yes 2 No 1 ☐ Yas 2 ☐ No certificate Division of Vital Attanding Physician: director, 25. Was case referred to medical Be 26. Place of Deeth (Check only one) Other: 4 Vursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 Yas 2 No this 28e. Date of Injury (Month, Dey Year) funeral 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: After 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Streat and Number or Rurel Route Number, City or Town, Stete) 4 Homicide ò 24 hours edicai 29a. Certifier 1 Lecrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner es steted. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. To the P within 2 To the I 29d. Date signed (Month, Dev. Year) 29b. Signature and title of certifier 29c. Licensa number 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) de 1413 rain 24 31. Date filed (Month, Day, Year) 32. Pégistrar's Signature State AUG 2 1 1998 Registrar

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Deeth Day ugus Susan Lois 1998 Yenser 4b. City, Town, or Location of Death 4c. County of Death 4e Fecility Neme (If not institution, give street end number) HOSPITAT (In yrs. lest birthday) If Under 1 Yea Months Day SHADY GROVE 5. Social Security Number ADVENTIST MONTGOMERY 7. Age (In yrs. lest birthday) e (State or Foreign 9. Birthplece Country) 6. Sex Days 1 M 2 F 86 179-05-5282 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10a. Stete 10b. County 10d. Inside City Limits 1 ☐ Yes 20XNo Maryland Howard Mount Airy 10e. Street end Number 10f. Zip Code 10g, Citizen of Whet Country? 17425 Frederick Road 21771 U.S. A. 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian, 12. Was Decedent Ever In U,S. Armed Forces? 11. Maritel Status Black, White, etc. 1 ☐ Yes 2 ₺ No If Yes, Give 1 Never Married 2 Merried 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☑ Widowed 4 □ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own home 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Craig Thomas Mary Ellen Kreger 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) Hazel Parry - Friend 17425 Frederick Road, Mount Airy, Maryland 21771 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Burial 2 □ Cremation 3 □ Removal from State Towamensing Cemetery 8/17/98 Palmerton, Penna. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service-Licensee 22. Name and Address of Fecility Olin L. Molesworth, P.A., Funeral Home 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, Approximate Approximate Approximete Intervel Between Onset end Deeth Immediate Ceuse (Final Acute Myocardial Infarction 40 minutes diseese or condition resulting in deeth) Due to (or es e consequence of): Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Last Due to (or es a consequence of) Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably XXUnknown 24b. Were eutopsy findings eveileble prior to 24e. Wes en eutopsy completion of cause of deeth? 1□ Yes 21 No 1 ☐ Yes ≱ No

Physician /Medical Examiner

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P.O. Box 68760

Records,

Division of Vital Attending Physician: **Physician**

/Medical

Examiner

Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Example: must be notified at

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permit. Peges 1 end 2 should be filed within 72 hours effer to Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural", or han any injury or other traumate.

Maryland 21215-0020

Baltimore,

Examiner buriel-transit the 98 esn 50 deteched signed t pege 2 director, funeral

Physician/Medical by Completed Be 2 Certification:

25. Wes cese referred to medical 1 Yes 2 No 27. Menner of Death

29b. Signature and the officertifier

5 Pending investigation 1 X Neturel 2 Accident 3 Sulcide 6 Could not be 4 - Homicide

28e. Dete of Injury (Month, Dey Yeer) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28c. Injury et Work?

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

1 ☐ Inpatient 2 ☑ ER/Outpetient 3 ☐ DOA

28b. Time of

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

28d. Describe how injury occurred

Other: 4 Nursing Home 5 Residence 8 Other (Specify)

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end manner stated. 29c, License number 29d. Date signed (Month, Dev. Year)

26. Place of Deeth (Check only one)

30 Jume end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print)

Hospital:

DAVIO G. Shour M.D

AUG 1 7 1998

9901 Medical Center Drive, Rockville, Maryland 20850

31. Date filed (Month, Dey, Yeer) State Registra

edicai

29e. Certifier

32. Redistrer's Signature

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🔾 🏻 Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Dete of Daath 3. Time of Death ALLEN 5 E T. 03. 1998 HILBERT 4a. Fecility Nama (If not institution, giva streat end number 4b. City, Town, or Location of Daath 4c. County of Death Church Home Hospital **Baltimore** N/A If Under 1 Yaar If Under 24 Hrs. 8. Data of Birth (Month, Day, Yaer) 5. Social Security Number 7. Aga (In yrs. last birthdey) Birthplaca (Steta or Foraign Country) 1 M 2□ F Deys Hours 75 Yrs. 212-20-4135 Jan. 13,1923 Maryland Usual Rasidanca of Decadant 10e State 10h County 10c. City, Town or Location 10d. Inside City Limits N/A **Baltimore** 1 Yas 2 No 10e, Straat and Number 10f. Zip Coda 10g. Citizan of What Country? 405 N. Lakewood Avenue 21224 U.S.A. 12. Was Dacedant Evar in U,S. Armad Forcas? 1 XYas 2 No W.W.II 13. Was Dacedant of Hispanic Origin? (Specify Yas or No-It Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 1 Navar Married 2 Married 1 Yas 2 No Specify: Specify: White 3 ☐ Widowad 4 ☐ Divorced 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Spacify only highast grade complated) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) Collega (1-4or 5+) Electronic Repair **U.S.**Goverment 17. Fathar's Name (First, Middla, Last) 18. Mother's Nama (First, Middla, Maidan Surneme) Thomas S. Allen Elizabeth I. Rothenberg 19e. Intormant's Name/Ralationship (Typa, Print) 19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Thelma Allen / Sister 405 N. Lakewood Ave., Baltimore, Md. 21224 20a. Method of Disposition 20b. Place of Disposition (Nama of camatary, cramatory or other piece) 20c. Location - City or Town, Stete 1X Burlal 2 Cramation 3 Ramoval from Steta 9-5-1998 Baltimore, Md. 4 ☐ Donetion 5 ☐ Other (Spacify) Oak Lawn Cemetery 21. Signature of Funeral Service Lis 22. Name end Addrass of Facility Moran-Ashton-Dabrowski Funeral Home, Inc. 3000 E. Baltimore St., Baltimore, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such es cardiac or respiretory errest, shock, or haert tailure. List only one cause on each line. Onset and Death Immediate Causa (Final disease or condition rasulting in deeth) NON HOGKINS LYMPHOMA. YEARS Sequantially list conditions, if any, leading to immediata causa. Enter Undarlying Causa (Diseasa or injury that initiated evants rasulting in deeth) Last Due to (or es e consequence of). Due to (or as e consequance of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown PNEUMONIA CORONARY HEART DISTAGE 24b. Wara eutopsy findings eveilebla prior to completion of causa 24a. Was en autopsy performed? 1 Yas 2 No 1 Yas 2 PNo 26. Placa of Death (Check only ona) Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) Hospitel: 1 ☑ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

Physician/Medical Examiner The law requires that the death certificates signed by t þ Completed his certificate has but director, page 2 sf or Attending Physician: Be 2 this funeral Certification: After after death.

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To the Hospital within 24 hours a To the Funeral Completely filled Hospital

Division of Vital Records, P.O. Box 68760,

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Maryland 21215-0020

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27. Mennar of Death 1 Matural 5 Pending Invastigation

28a. Data of Injury (Month, Dey Year)

28b. Tima of

28c. Injury at Work? 1 ☐ Yas 2 ☐ No

28d. Dascribe how injury occurred

6 Could not be datamined 28a. Place of Injury - At home, farm, straat, factory, office building, atc. (Specify) 4 Homicide

28f. Location (Streat and Number or Rural Route Number, City or Town, Stata)

29a. Certifian (Check only one)

2 Accident

3 Suicide

1 Cortifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and mennar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and mannar stated.

29b. Signatura and titla of certifiar

A-P- Novgerns no

29c. Licansa number 017322

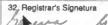
29d. Dete signed (Month, Dey, Yeer) SEPT. 03, 1998

30. Nama and address of person who complated cause of death (Item 23a) (Type, Print)

A-P. NAZEMI, M.D. CHUNCH HOSPITAL. BALTIMO. 21231

State Registrar

31. Deta tiled (Month, Day, Yaar) SEP 04 1998



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Day **Physician** 4b. City, Town, or Location of Death 4c. Cou itdams Diane 1998 6:50pm /Medical 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner Howard County Howard County General Hosp. Columbia 7. Aga (In yrs. last birthday) If Undar 1 Yaar Months Days If Undar 24 Hrs. 8. Data of Birth
Hours Min. (Month, Day, Yaer) 5. Social Security Number Birthplaca (Stata or Foreign Country) **Funeral** 1 M 2 F Director 141-60-7278 Usual Rasidanca of Decedant May 30, 11959 New Jersey XX 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits r then "naturel", or learns 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yas 2 ☐ No Directo Maryland Howard County Columbia 10e. Street and Number 10f. Zip Coda 10o. Citizen of What Country? 21044 IKA 11880 Blue February Way 13. Was Decedant of Hispanic Orlgin? (Specify Yas or No-lf Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 12. Was Decedant Evar In U,S. Armed Forcas? 1 Yas 20000 11. Marital Status 72 hours after 1 Nevar Marriad 2 Married white Baltimore, Maryland 21215-0020 1 Yas 2 XXX Spacify: If Yas, Giva Yaar or Datas: Specify ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada complated) filed within Hygiana. other than Elamantary/Secondary (0-12) Collega (1-4or 5+) education teacher/counselor permit. Pages 1 and 2 ahould be life.
Department of Health and Mental Health and Mental Health and Mental Health any Injury or other marked other 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fethar's Nema (First, Middla, Last) Be Mary Ann Noble Arthur H. Shaner, Jr. 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. informant's Name/Ralationship (Type, Print) 11880 Blue February Way, Columbia, MD 21044 Joseph Adams/spouse 20b. Placa of Disposition (Nama of camatary, cramatory or other placa) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cramation 3 ☑ Bamoval from Stata 4 ☐ Donation 5 ☐ Other (Spacify) Henlopen Memorial Park 1SFP98 Milton, Deleware 21. Signatura of Funaral Servica Licensaa 22. Nama and Addrass of Facility Slack Funeral Home, P.A. 23a Part1. Enter the disease, or somplications that caused the death. Do not anter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Daath **Physician** /Medical Immadlata Causa (Final disease or condition resulting in death) a Respirator 21 days **Examiner** Examiner metastatic to lunge (cervice) Cancer The law requires that the death certificate be executed physician and s the burial-trans Sequantially list conditions, if any, laading to immadiata ceuse. Enter Underlying Cause (Disaasa or injury that initiated events resulting in deeth) Last Dua to (or es e consequença of) Records, P.O. Box 68760 Physician/Medicai Dua to (or as a consequence of): signed by the e Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 ANO 3 Probably 4 Unknown obstructive premion a þ 24b. Wara autopsy findings available prior to been si 24a. Was an autopsy Completed effusions anorenia/cachesin syndian completion of causa of death? nis certificate has b I director, page 2 sl 1 Yas No 1 ☐ Yas 2 No Division of Vital l or Attending Physician: after daath. 25. Was casa raferrad to medicel examiner? Be 26. Placa of Daath (Check only ona) 1 Yas 20 No Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 1 Inpatiant 2 □ ER/Outpatient 3 □ DOA this After thi funeral 28a. Deta of Injury (Month, Dey Year) 27. Manner of Death 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Invastigation 1 Natural 1 Yas 2 No 2 Accident Director: / 6 Could not be datarmined 3 Sulcida 28a. Place of Injury - At homa, farm, streat, factory, offica building, atc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stete) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completaly filled in 29a. Cartifiar 1 Certifying Physicfan: To the bast of my knowledge, death occurred at the time, data and place, and due to the causa(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and mannar stated. edicai (Check only one) 29b. Signatura and little of certifier 29c. Licansa number 29d. Data signed (Month, Day, Year) D30573 2-30-98 30. Name and address of person who complated ceusa of death (Itam 23a) (Type, Pani) 2 Knoll North K. Minford MD Columbia MD 21045

DHMH 16 Rev 6/95

State

Registrar

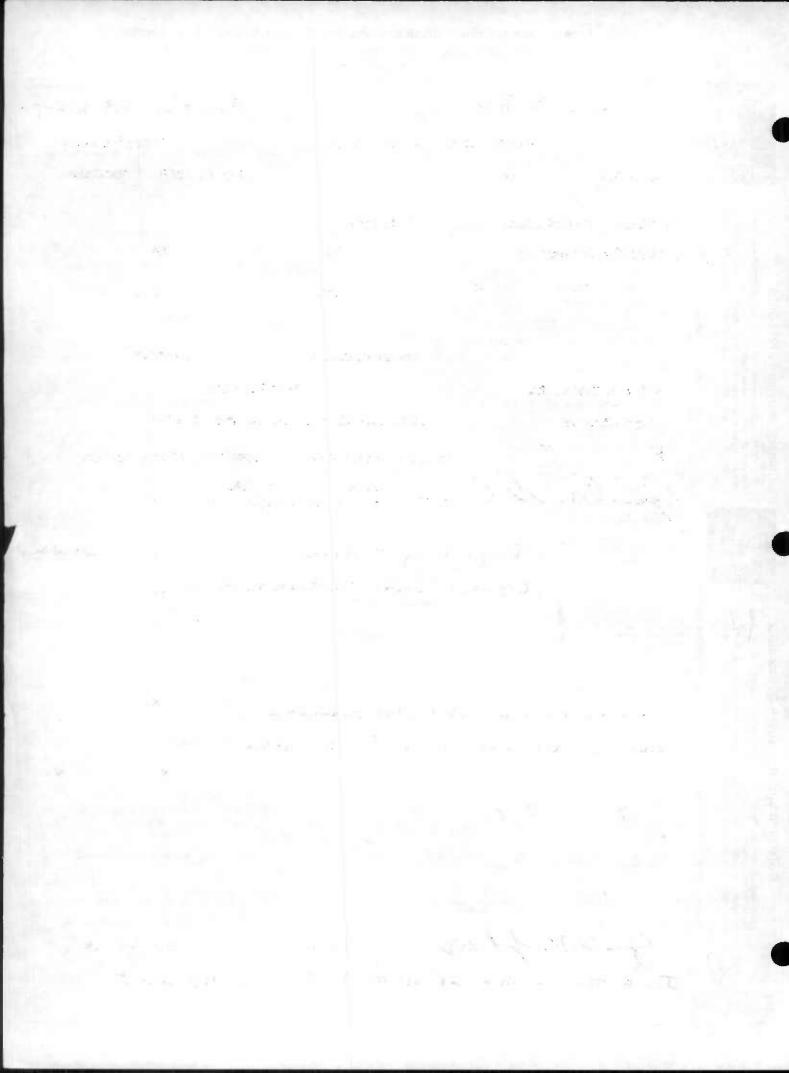
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32. Registra/s Signatura

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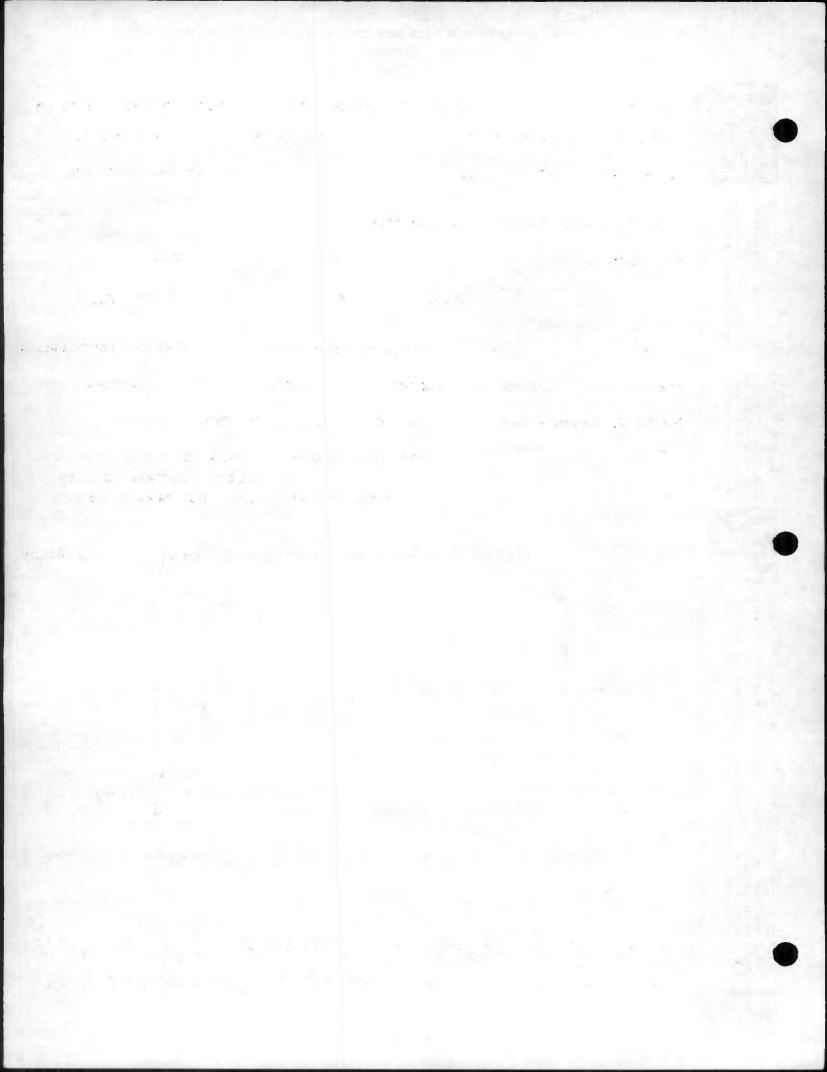
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State of Maryland / Department of Health and Mental Hygiene 9 8 27 1 1 (

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N 0 9 6	19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Ma	lling Address (S	treet and Number o	or Rural Route Number,	City or Town, State,	Zip Code)				
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To the Hospital within 24 hours e To the Funeral D completely filled i Medical Ce	29a. Cartifliar (Check only one) 29a. Cartifliar (Check only one) Certifying Physician: To tha best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause and manner stated.											
To th Comp	29b. Signature and office of certifier	MAS	1	29c. Li	censa number	5/ 54	ed. Data signed (Mo	nth, Day, Year)				
10	39. Nama and addrass of person who co	embleted causa of death (Ite	m 23a) (Typ	e, Print)	in High	197 Glen	Burnier	1.7/06/				
State	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	6. Se	racks	, ,	N. C.					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** BISHOP EMMA SEPTEMBER 3 1998 12.05 pm /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) Examiner Hospital Center Baltimore Horobor N/A 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey. Year) 5. Sociel Security Number Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 K F Deys Hours Yrs. 06-04-1914 Director 217-03-6736 Maryland Usual Residence of Decedent the Maryland 10a Stete 10h County 10c. City. Town or Location 10d. Inside City Limits r 28a-f show Yes 2 No Directo Maryland N/A Baltimore 10e. Street end Number 10f. Zip Coda 10g. Citizan of Whet Country? filed within 72 hours efter death with it Hygiene. r than "natural", or items 23a or the Medical Examiner must be 21223 U.S.A. 1342 James Street Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give WW II Year or Dates: Was Decedant of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Meritel Stetus Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ▼No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grede completed) Elamantary/Secondary (0-12) Collega (1-4or 5+) 12 Years N/A . Peges 1 and 2 should be filed w ment of Health end Mentel Hygier tant: If Nem 27 Is marked other th Jury or other traumatic event, the Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Annie Smith August Bischoff 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) 1342 James Street Baltimore, Maryland 21223 (Husband) John A. Bishop, Sr. 20b. Place of Disposition (Nama of cametery, crematory or other plece) 20c. Location - City or Town, State 1 ☐ Buriel 2 ☑ Cremetion 3 ☐ Removel from State Hilltop Services Corp. 9-4-98 Towson, Maryland 4 ☐ Donetion 5 ☐ Othar (Specify) 22. Name end Address of Facility Leonard J. Ruck, Inc. 21. Signature of Funeral Fervica Licansee J WAyne Osterling 5305 Harford Road Baltimore, Maryland e, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, list only one cause on each line. 21214 Approximete Interval Between Onset and Death Physician /Medical Immediate Cause (f disease or condition rasulting in death) SEPSIS Examiner Due to (or es e consequence of): 3 Weeks Examiner PNEUMONIA Sequantially list conditions, if eny, laading to immediate cause. Entar Underlying Causa (Disaesa or injury that initiated events resulting in deeth) Lest Due to (or as e consequence of): Box 68760, ACUTE FROM ULCERATIVE COLITIS BLEED Physician/Medical Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? ed by the a Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Ponknown CONGESTIVE HEART FAILURE by S g 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Was en autopsy Completed HYPERTENSION is certificate has t director, page 2 s 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Plece of Death (Check only one) Othar: 4 Nursing Home 5 Residence 6 Other (Specify) To Hospital: 1 Impatiant 2 ER/Outpatient 3 DOA 1 Yes 2 No funeral 28a. Data of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: After 1 Naturel 5 Pending s effer dec. 1 ☐ Yes 2 ☐ No investigation 2 Accidant 6 Could not be datarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 4 - Homicida pelli 24 hours 1 Certifying Physician: To the best of my knowledga, death occurred at tha time, date end plece, and dua to tha causa(s) end menner as stated. 2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at tha time, date end pleca, end dua to the cause(s) end menner stated. 29a. Certifier To the Hosp within 24 hou To the Fune completely fi edicai 29d. Date signed (Month, Day, Year) Resident Physician 29c. License number 29b. Signeture and title of cartifier · Nasipaferz AS 2441614-41 SEPTEMBER 3, 1998

State

Registrar

31. Dete filed (Month, Day, Yeer)

SEP 4 1998

30. Name and address of person who completed cause of death (Itam 23e) (Type, Print)

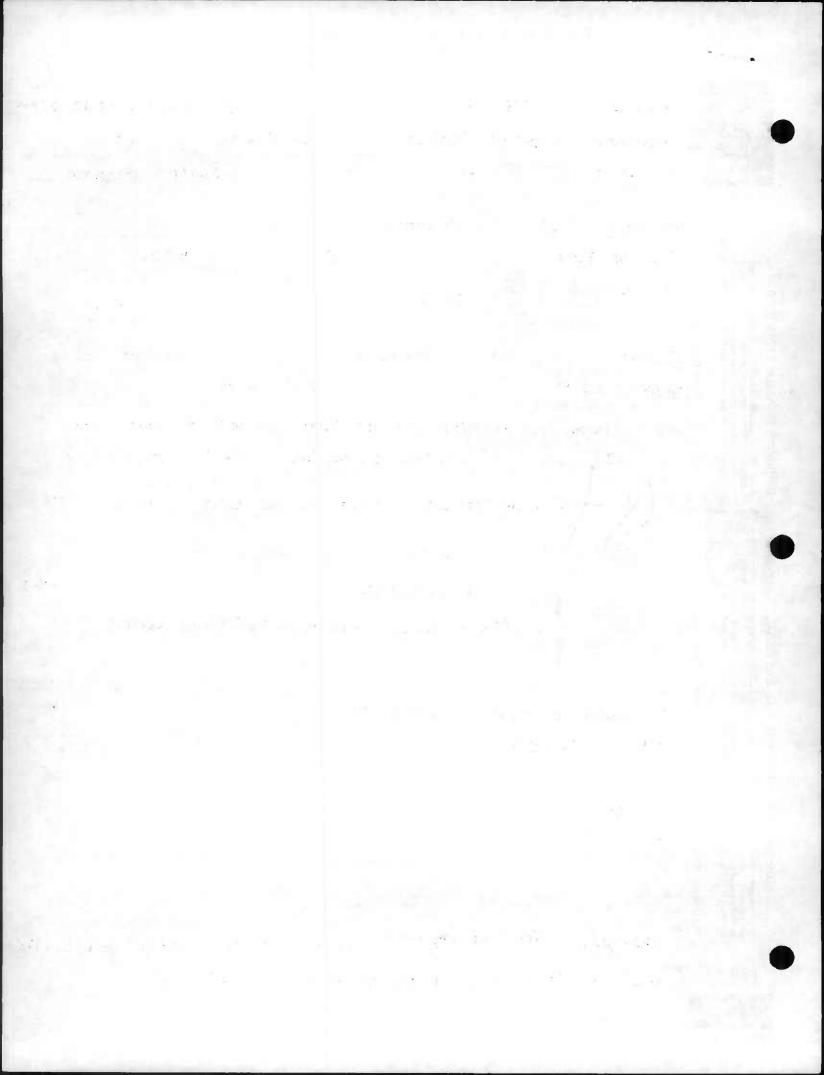
SYED N ZAFAR, HARLBOR

32. Register's Signature

HOSPITAL CENTER

HAR BOR

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 3. Tima of Deeth 1. Decedant'a Nama (First, Middle, Last) august OUEENIE ELIZABETH BARBOUR 09:33am 4b. City, Town, or Location of Daath 4a Fecility Nama (If not institution, give street end number) 4c. County of Death UNION MEMORIAL HOSPITAL BALTIMORE N/A If Undar 1 Yaar | if Undar 24 Hrs. 8. Data of Birth (Month, Dey, Yeer) 9. Birthplaca (State of Country) Maryland 7. Aga (In yrs. last birthday) Birthplaca (State or Foreign Country) Months Days Hours 1 □ M 200 F 145-42-3435 46 Yrs. Usuel Rasidance of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits MD N/A 1 Yas 2 No Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1221 Linworth Avenue 21239 U.S.A. 12. Wes Decedant Ever in U,S. Armed Forcas? Was Dacedant of Hispanic Origin? (Specify Yes or No-ff Yas, specify Cuben, Mexican, Puerto Ricen, atc.) 14. Race - Amarlcen Indian, Black, Whita, etc. 1 ☐ Yes 2 ☑ No If Yes, Giva Year or Detes: 1 Naver Married 2 Married 1 ☐ Yas 2X No Specify: **Black** 31☑ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) Restaurant Domestic 12th 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fethar's Neme (First, Middle, Last) Deloris Taylor Morris Lester 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Kenneth Barbour 47 North 13th Street, Hawthorne, NJ 07506 20b. Plece of Disposition (Neme of cemetery, cremetory or other piece) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from Stata Fairlawn Cemetery 9/5/98 Fairlawn, New Jersey 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Addrass of Facility WILLIE LEROY O. DYETT & SON E. HOWELL JR. P. A 4600 LIBERTY HEIGHTS AVE., BALTO., MD21207 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximete interval Between Onset end Deeth immediata Causa (Final disaasa or condition rasulting in daath) (or es e consequence of): Dreumania Sequantially list conditions, if eny, laading to immediata ceusa. Entar Undarlying Ceusa (Diseasa or injury that initiated avants Due to (or es e consequence of). resulting in death) Last Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown MA 24b. Wera autopsy tindings available prior to 24a. Was an autopsy performed? complation of ceusa of death? 20 No 2 No 1 Tyes 25. Wes casa referred to medical exeminar? 26. Placa of Daath (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No 1 Inpatiant 2 □ ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Dey Year) 27. Mannar of Death 28b Time of 28c. injury at Work? 28d. Dascribe how injury occurred 1 Naturai Accident 5 Panding 1 ☐ Yas 2 ☐ No investigation

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efter death Director: Hospital 24 hours within 2 eq.

> State Registrar

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item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Exemples must be notified at

permit. Peges 1 end 2 should be filed within 72 hours efter deeth v. Department of Health and Mental Hydrens. Important: if item 27 is merked other than "natural", or items 23a any injury or other traumatic avant.

Physician /Medical

Examiner

altimore, Maryland 21215-0020

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and manner stated. 29b. Signatura and titla of certifiar

🛣 Certifying Physician: To tha best of my knowledga, death occurred at tha tima, data and place, and dua to tha cause(s) end mannar as stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

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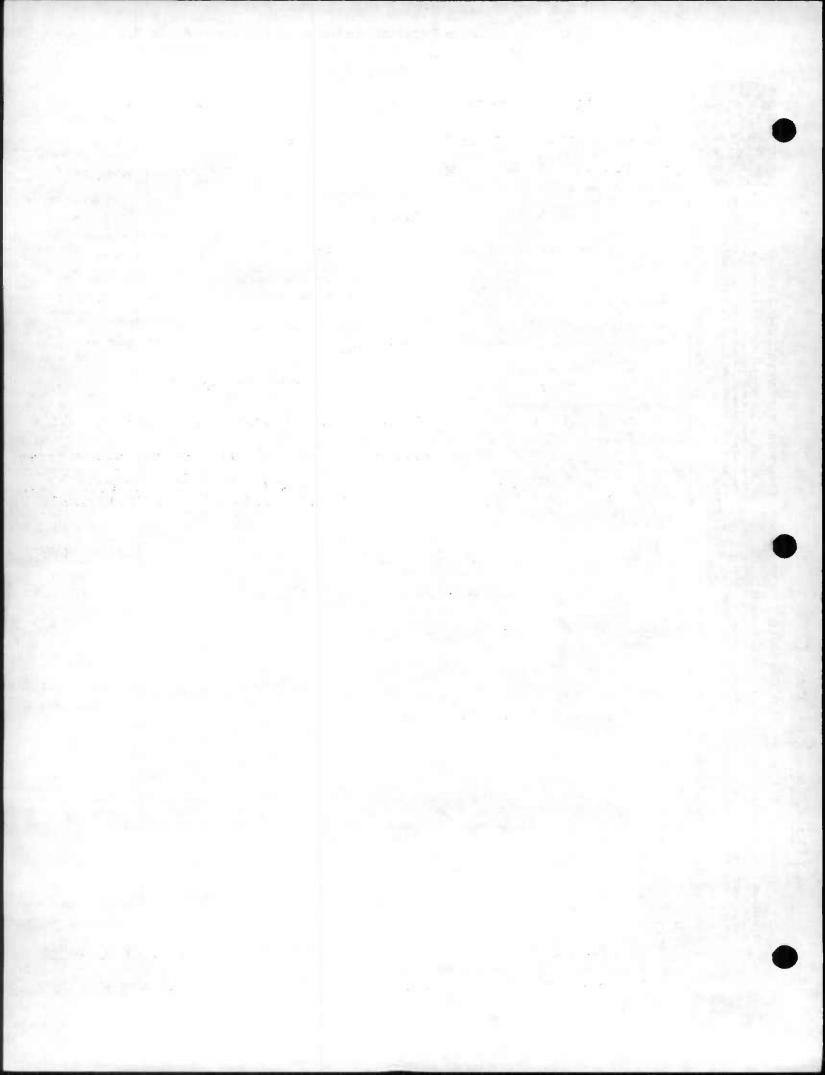
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30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) MoHer

2400

28a. Place of injury - At homa, farm, straat, factory, office building, atc. (Specify)

32. Ragistrar's Signatura



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month **Fdm** md Broczkowski 4:30PM August 31,1998 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth 5901 Eurith Ave. Raspeburg Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthdey) 9. Birthplece (State or Foreign Deys Months 1 M 2 □ F 215-16-2805 75 Vre Usuel Residance of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Raspeburg 1 Yes 2 No 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Number 21206 5901 Eurith Ave. USA 14. Race - American Indian, Bleck, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11. Meritel Stetus 1 ☐ Never Married 2 ☑ Married TYes 2 No Mes, Give 1 ☐ Yes 2 ☑ No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Korea 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) State of Maryland Systems Analyst 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Surname) Gutowski Broczkowski Katherine Julius 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) Frances Broczkowski/wife 5901 Eurith Ave. Baltimore, MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) Sacred Heart of Jesus 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify) 9-4-98 Baltimore, MD 22. Name end Address of Fecility Cvach/Rosedale Funeral Home 21. Signature of Runeral Service Lio 1211 Chesaco Ave. Rosedale, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one ceuse on each line. Approximete Interval Batween Onset end Deeth Immediate Ceuse (Final diseesa or condition rasulting in daath) recurre Sequentially list conditions, if eny, leading to immediata causa. Entar Undarlying Ceuse (Disaase or injury that initiated evants resulting in deeth) Lest Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Part tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings evailable prior to 24e. Wes an autopsy performed?

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

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Show

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r than "naturel", or items 23s or 28s-f shorthe Medical Examiner must be notified at

Pagas 1 and 2 should be filed within 72 hours after of the Haalth and Mental Hyglena.
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Baltimore, Maryland 21215-0020

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Examine physician end s the burial-transit Physician/Medical as use signed by the a d be detached f by Completed certificate has b lirector, page 2 s Be 0

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The lew requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, funeral filled in by

24 hours after deet Funeral Director: Hospital of within To the

Certification:

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29b. Signature and title of certifi

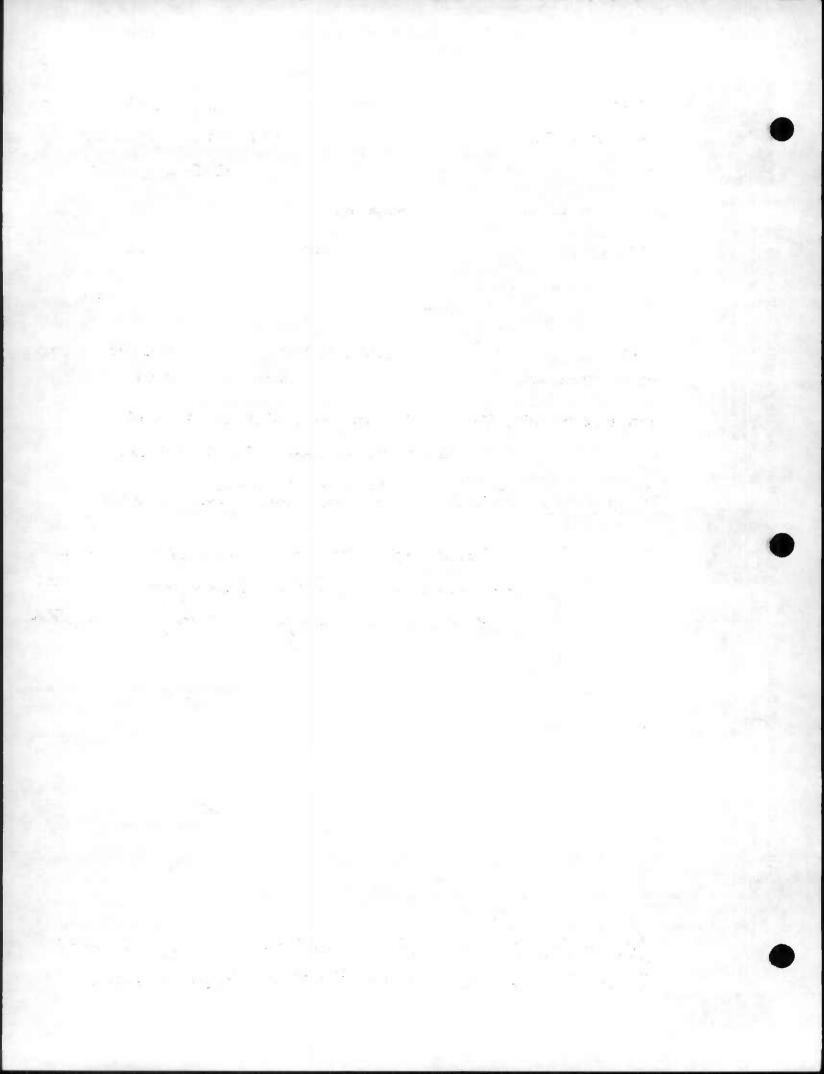
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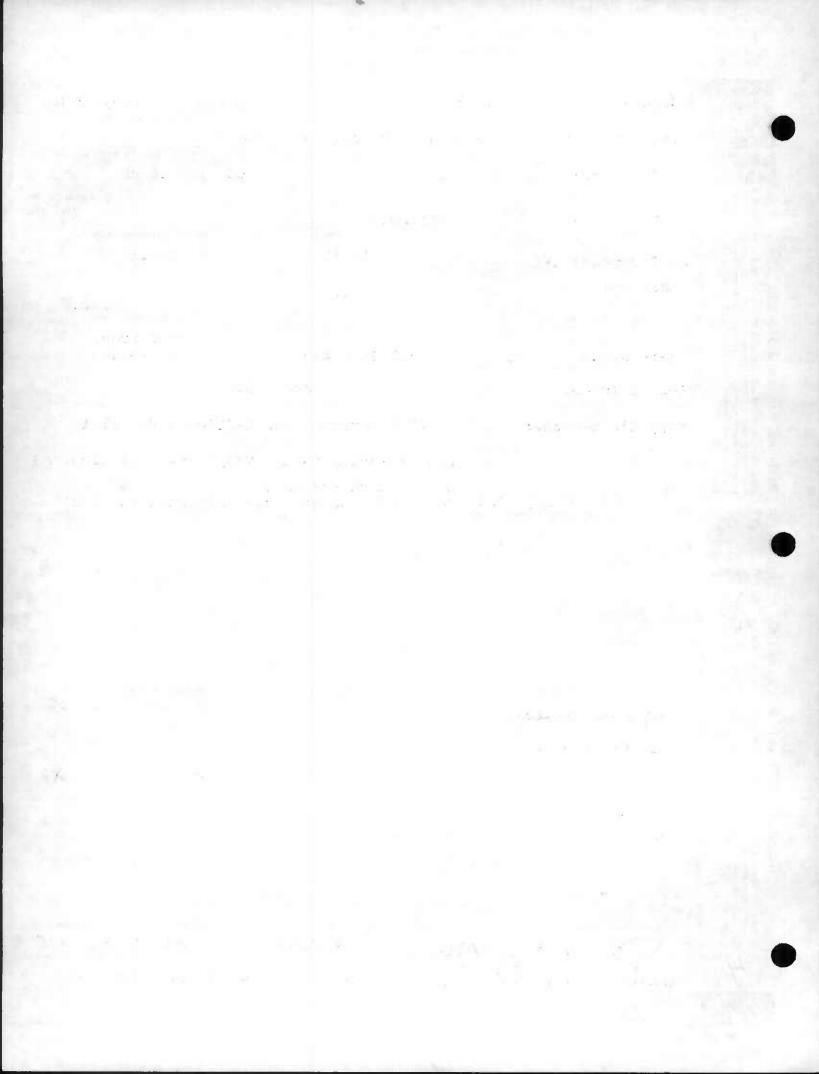
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62. Registrar's Signatur

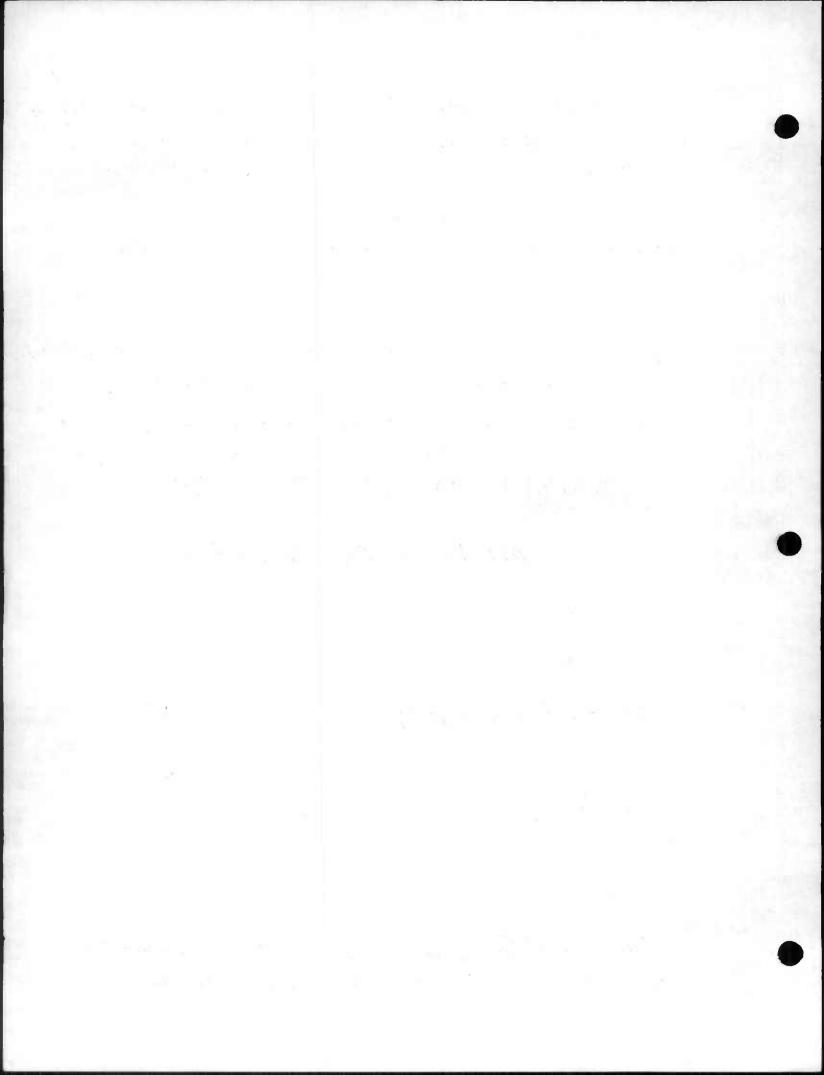


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	n 24 n Fu ne Fu	edical	(Check only 2 Medical Exa	minar: On the basis of and mannar sta		ind/or investigati	on, in my o	opinion, daath	occurred at the time	, data and place	e, and dua to	o tha caus	3e(S)	
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certific completaly filled in by the funeral director,	X	29b. Signatura and titla of certifiar					se number		29d. Date sign				
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					Certificate of	Death	Re	g. No.	2/12/						
	Physic	ion	1. Decedent's Name (First, Middle, Lest)				2. Dete of Death Month	Dey Ye	3. Time of Deeth						
	/Medi		Blanche E.	Calver	t		SEPT.	3, 199							
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	Funeral Director		215-03-9961 ¹□M ※FF 9	(In yrs. last birt	thday) If Under 1 Year Months Deys										
	pur »		Usual Residence of Decedent 10e. State 10b. County	10c. City, Town	n or Location				10d. Inside City Limits						
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	28a-	Director	19 IV A	Dalti	10f. Zip Code		10	g. Citizen of What	Λ						
	ath with	ral Di	614 Maude Avenue		21225			USA							
020	Till life in		11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Wes Decedent E Armed Forces? 1 □ Yes 2 ☑ No. If Yes, Give A Year or Dates:		13. Was Decedent of If Yes, specify Cub		ecify Yes or No- Rican, etc.)		white, etc. White						
21215-0020			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5-		Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	during most of work ed)	ing	6b. Kind of Busine							
7	e filed w al Hygier other th		12		Bookbinde	-			ding Facto						
anc	S da S	Be	17. Fether's Neme (First, Middle, Lest) Andrew Brown Dawso	n		18. Mother's Nam		telle E	liana						
Š	should be nd Mental markad or umatic eve	To							00						
Maryland	d 2 ch ar		19e. Informent's Name/Relationship (Type, Print)		. Meiling Address (Stree										
	es 1 end 2 of Health I item 27 i		Victoria I. Calvert/dau 20e. Method of Disposition	20b. Place of	DI4 Maude Disposition (Neme of y, cremetory or other pla		Date 2	more, Noc. Location - City	D ZIZZ5 or Town, Stete						
E	Pages nent of I int: If ite		1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify)		Cremato		9/4/98	Baltimo	ore, MD						
	permit. Pages Department of Important: If It any Injury or once.		21. Signature of Funaral Service Ligansee	ald	Crematic	ss of Socie	ty of M	aryland	, Inc.						
			21. Signature of Fundral Service Lieensee C C Cremation Society of Maryland, Inc. Dawn F. McDonald 299 Frederick Rd. Baltimore, MD 21228 239. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, Intervel Between Onset end Deeth Onset end Deeth												
	/Medical Examiner		b	Oue to (or es e o	consequence of:	e Dem	enti	9							
	law requires that the death certificete ba. es been signed by the ettending physicfa s 2 should be deteched for use as the bur	in/Medical		ue to (or es e c	consequence of):										
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Records,	e law requires hes been sign ge 2 should by	Completed b		V			24a. Wes er perform		tb. Were eutopsy findings eveileble prior to completion of ceuse of deeth?						
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I a	certificate rector, pay	Be	25. Wes case referred to medical examiner?			26. Plece of Deet	h (Check only one)							
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=	or At	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number of Town, Stete)												
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	->-0		Assen Coul Court	1 di	m no	1459		9-4-	-98						
,	2		30. Name end eddress of person who completed cause of dei	3th (frem 23e) ((Type, Print) 47(1) Do.	iningfe	n Ack	enue	10						
	Sta	ate	31. Dete filed (Month, Day, Year) 32. Registrer	's Signature		7/6	1								
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Franci William Cullon Nome

DHMH 16 Rev 6/95

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15. Mother's Name (First, Middle, Lead) 15. Mother's Name (First, Mi			Jary (0-12)			Eng	ineer				Plastic	cs		
19b. Mailing Address (Sineat and Number or Rural Route Number, City or Tow). State, Zip Code) Jack Kerns/Nephew 19b. Mailing Address (Sineat and Number or Rural Route Number, City or Tow). State, Zip Code) 4300 N. Charles St., Apt. 6E, Balto., Md 21218 20b. Rate of Dispession (Paral Route Number, City or Tow). State 2 (December 1) 10 Burlai 2 (Demanation 3 Ramoval from State 1) 20b. Repear of Dispession (Paral Route Number, City or Tow). State 2 (December 1) 21d. Signature 3 (December 1) 22d. Paral Route Number or Rural Route Number, City or Tow). State 2 (December 1) 22d. Rate of Dispession (Paral Route Number) 22d. Rate of Dispession (Paral Route Number) 22d. Paral Route Number or Rural Route Number, City or Tow). State 2 (December 1) 22d. Rate of Dispession (Paral Route Number) 22d. Rate of Data (Specify) 22d. Rate of Data (Paral Route Number) 22d. Rate of Data (Specify) 22d. Rate of Data (Paral Route Number) 22d. Rate of Data (Paral Route Number) 22d. Rate of Data (Paral Route Number) 22d. Route of Data (Paral Route Number) 22d. Cariffer 22d. Data signed (Month, Day, Ye	17. Fathar's Nama (First, Middla, Last)													
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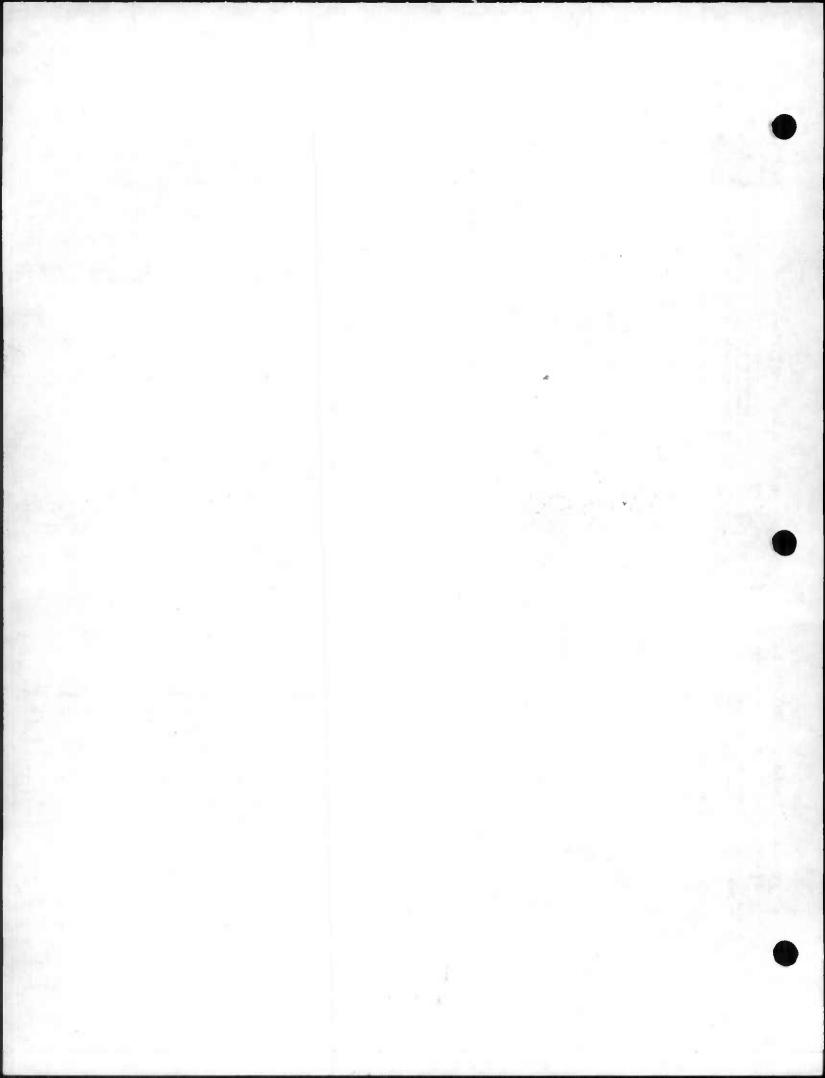
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State of Maryland / Department of Health and Mental Hygiene 98 27 | 23

			Cei	tificate o	of Death		Re	eg. No.	-	1120		
	1. Decedent's Nema (First, Middla, Las	st)	1111				ate of Deat	h	Vana	3. Tima of Death		
Physician /Medical	LOUISE D.	CHAPPLE					Month	28, 199	Year 8	10:05pm		
Examiner	4a Facility Neme (If not institution, give			4b. City, Town, or Lo				4c. County				
	CROFTON CONVALESC	ENT CENTER			CROFTO	N		ANNE	ARUNI	EL		
ineral	5. Sociel Security Number 6. S	ex 7. Age (In yrs	s. last birthday)	If Under 1 Yo	ar If Under 2	24 Hrs. 8. D	Date of Birth Wonth, Day,	Voorl	9. Birthp	lace (Stete or Forei		
ector	577-88-1176 Usuel Residence of Decedant	□ M 2007F 89	Yrs.	Months De	ys Hours		rch 5			ington,		
of all	10a. Stete 10b. County	10c. C	ity, Town or Lo	cation					1	0d. Inside City Limi		
ust be notified at ral Director	Md. Montgome 10e. Street and Number 8109 Kennwick Avo		Takoma	Park 10f. Zip Coo 20912	e		1	Og. Citizen of US				
Examiner must by Funeral	11. Maritat Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Detes:		Was Decedent f Yes, specify C	of Hispanic Orig Juban, Mexican, No Specify:	gin? (Specify , Puerto Ricar	Yes or No- n, etc.)		ce - Americ ck, White,			
Completed	15. Decedent's Ed (Specify only highast gra	ucation da completed)	(Give	lent's Usuel Oc kind of work do	ne during most	of working		16b. Kind of B	usiness/Inc	lustry		
E E	Elemantary/Secondary (0-12)	College (1-4or 5+)		OO NOT use re	tired)							
	8		Нот	nemaker	40.00.00	an and the least of the second		own l				
Be	17. Fathar's Name (First, Middle, Last)				18. Mother			Aaiden Sumer	n <i>e)</i>			
2	Henry Howland					Lul		Suttle				
	19a. Informent's Neme/Reletionship (1				eet and Number					Code)		
reportant: If them 27 ny injuny or other tr 058.	James W. Chapple/son #11 Beaconhill Rd., Berlin, Md. 218											
	20e. Method of Disposition 1 Buriel 2 □ Cramation 3 □ 4 □ Donetlon 5 □ Other (Specif)	Removel from Stete	cemetery, cren	netory or other	etery			20c. Location 8 Brent				
Vedical Examiner	23a. Part1. Enter the disease, or companies of the shock, or heart feilure. List only immediate Ceuse (Finel disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Lest	b. Arte	estive (or as a conseq	Head uence of):	ek Rd., dying, such as a Farlum Hearl	cardiac or res	piratory arm	polis i	Rd.,]	Owne, Mo Approximate Interval Between Onset end Death / month		
Completed by Physician/Me												
pieted b							24a. Wes a perform	n autopsy ned?	COI	ara autopsy finding ailabla prior to appletion of cause death?		
E O							1 🗆 Y	s 2 No	10	Yas 2□ No		
BeC	25. Was case rafarred to medical				26. Place	of Deeth (Ch	eck only on	e)				
To B	exeminer?	Hospital: 1 Inpatient 2	ER/Outpatien	1 3 DOA	Other: /			nce 6 Ott	her (Specifi	1)		
	27. Manner of Deeth 1 ☑Neturei 5 ☐ Panding 2 ☐ Accident investigation	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. I	njury et Nork?	28d.		ow injury occur				
i Certification: 1		3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office							28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)			
edical Certification:	29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and dua to the cause(s) and manner as stated. (Check only one)											
X X	29b. Signatura and titla of cartifier	The state of the s		29c. Lic	ense number		2	9d. Date signe	ed (Month,	Dey, Year)		
	26 min) MD		1	5034	<	29d. Date signed (Month, Dey, Year) August 31, 1998 Bowie, Mayland 20715					
	30. Neme end eddress of person who co	ompleted causa of death (tte	m 23a) (Type,	Print)				rugusi	31/	/ / 70		
	Kelvin Hao M			Lane	Surt	e A-6	· #	Bowie,	Mary	land 207		
State gistrar	SEP 0 4 1998	82. Registrar's Sign	latura	Par d								



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month Elvira Μ. Christie September 2,1998 3:20 P.M. 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Larkin-Chase Nursing Home Prince George's If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 1□ M 2□ F 579 01 7289 91 Yrs. September 13,1906 Washington DC Usual Residence of Decedent 10e Stete 10b Counts 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes ANO Maryland Anne Arundel Crofton 10e. Street end Number 10f. Zip Coda 10g. Citizen of Whet Country? 1861 E. Queens Court 21114 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 220 No If Yes, Give Yeer or Dates: Was Decedent of Hispenic Origin? (Specify Yes or Notif Yes, specify Cuban, Maxican, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3⊠Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usuel Occupetion 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use ratired) (Specify only highest grade completed) Elemantary/Secondary (0-12) Collega (1-4or 5+) Machine Operator U.S.P.S. 17. Fether's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) Antonio Mercurio Clementine Morello 19a. Informent's Name/Raletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1861 E. Queens Court Crofton Maryland 21114 Ann R. Myers 20b. Plece of Disposition (Name of cemetery, crematory or other place) Sept. 5, Date 998 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Brentwood Maryland Fort Lincoln Cemetery 21. Signeture of Funerel Service Licenses 22. Name end Address of Fecility Robert E. Evans Funeral Home, Inc. 23e. PerV. Enter the disease, or combined shock, or heart failure. List only 16000 Annapolis Rd. Bowie Maryland 20715 Approximate Ap that caused the deeth. Do not enter Immadiate Cause (Final disease or condition resulting in deeth) Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disaasa or injury thet initieted events resulting in death) Lest Due to (or es e consequence of) Due to (or es e consequence of): Pert II. Other eignificant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 | Yes 2 | No 3 □ Probably Unknown 24a. Wes an eutopsy performed? 24b. Wera autopsy findings eveileble prior to completion of cause of daath? 1 ☐ Yas 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

r man "natural", or itams 23a or 28a-f shor the Medical Examiner must be notified at

Baltimore, Maryland 21215-0020

P.O. Box 68760,

Records,

Division of Vital

permit. Pages 1 and 2 should be filled w Department of Health and Mental Hygien Important: If from 27 is marked other this any Injury or other free

Director

Funeral

þ

Completed

Be

2

iding physician 88 signed by the at d be detached for After this death. ector: the Höspital or

ohysician and the burial-transit Physician/Medical by Completed Be 2 Certification: within-24 Rours at To the Eures D Complete Tiled edical

> State Registrar

25. Was cese referred to medical examiner?
1 ☐ Yes 2 No 27. Mennar of Death 5 Pending investigation Netural € ☐ Accidant 3 ☐ Sulcide

4 Homicide

29a. Certifian

6 Could not be determined

28b. Time of

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Piece of Injury - At home, farm, street, fectory, office building, atc. (Specify)

28c. Injury at Work?

29c. License number

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

Othar: 4 Nursing Homa 5 Rasidance 8 Other (Specify)

26. Placa of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

15 Certifying Physicien: To the best of my knowledga, deeth occurred et the time, deta and plece, end due to the ceusa(s) end mennar es stetad.
2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to tha ceuse(s) and menner stated.

29d. Date signed (Month, Day, Year)

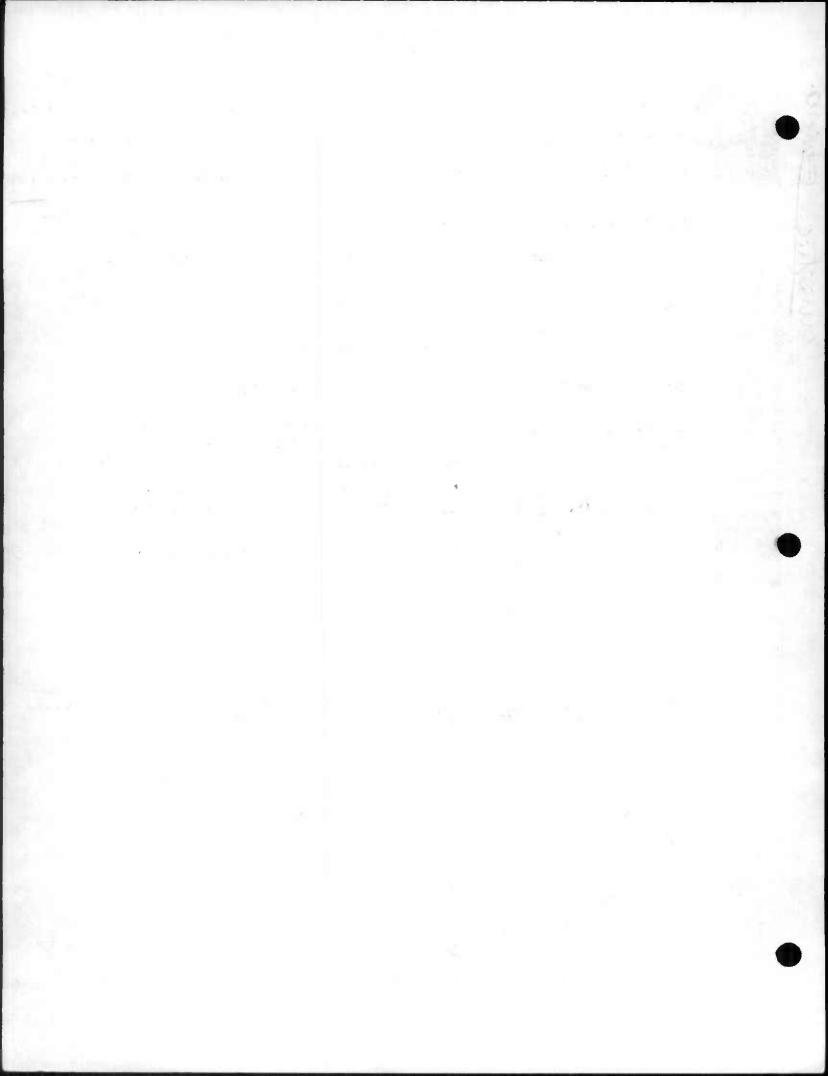
30. Name end eddress of person who completed ceusa of deeth (Item 23e) (Typa, Print 1000 Mit MA

31. Dete filed (Month, Day, Year) SEP 0 4 1998

29b. Signature end title of certified

32. Registrer's Signeture

DHMH 16 Rev 6/95



To the Fune completaly f

To the I within 2

State Registrar

(Check only one)

29b. Signeture end title of certifie

HEVDONE MIKM 32 Registrer's Signeture

2 eddress of person who completed cause of deeth (item 23e) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

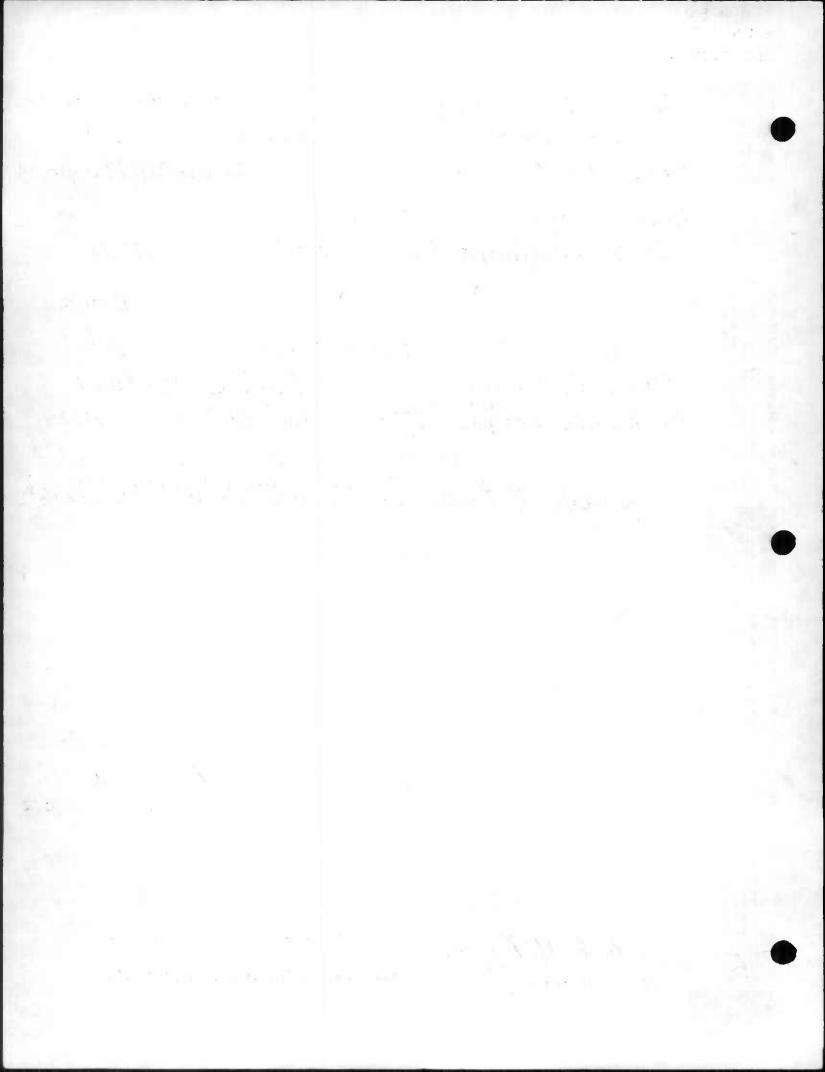
29c. License number

O.C.M.E

29d. Date signed (Month, Dey, Year)

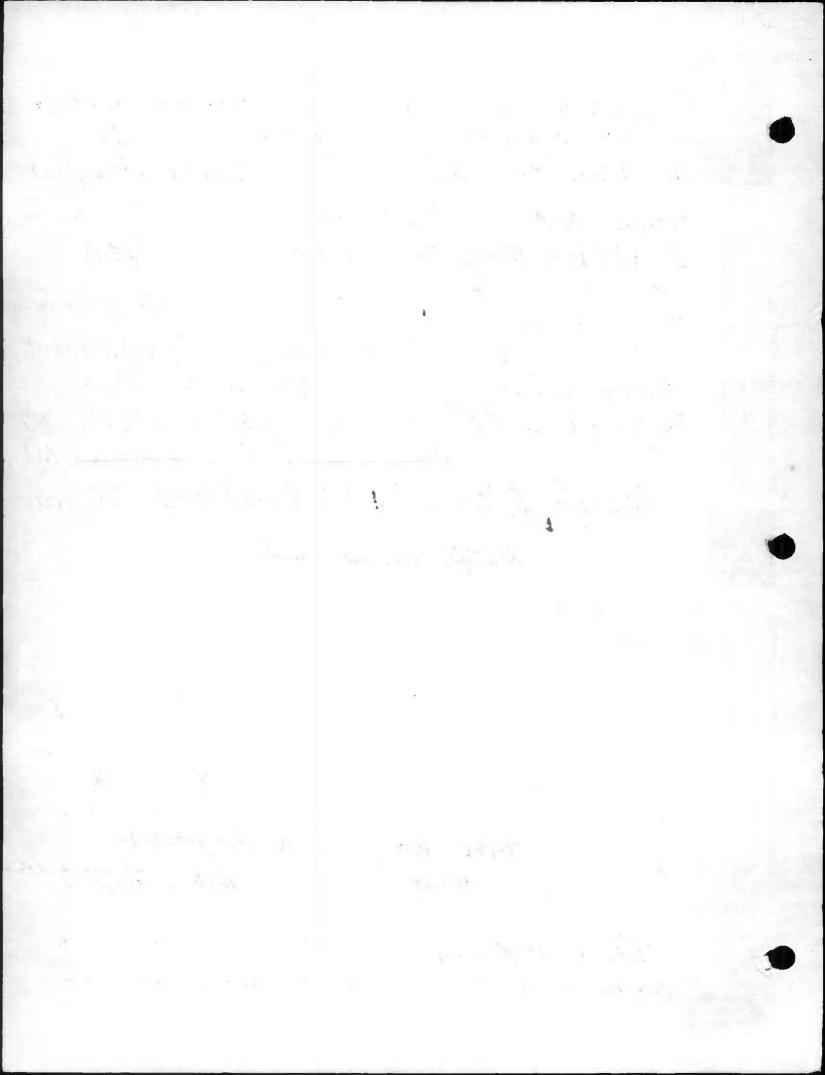
SEPT. 3, 1998

31. Date filed (Month, Day, Year) SFP 0 4 1998

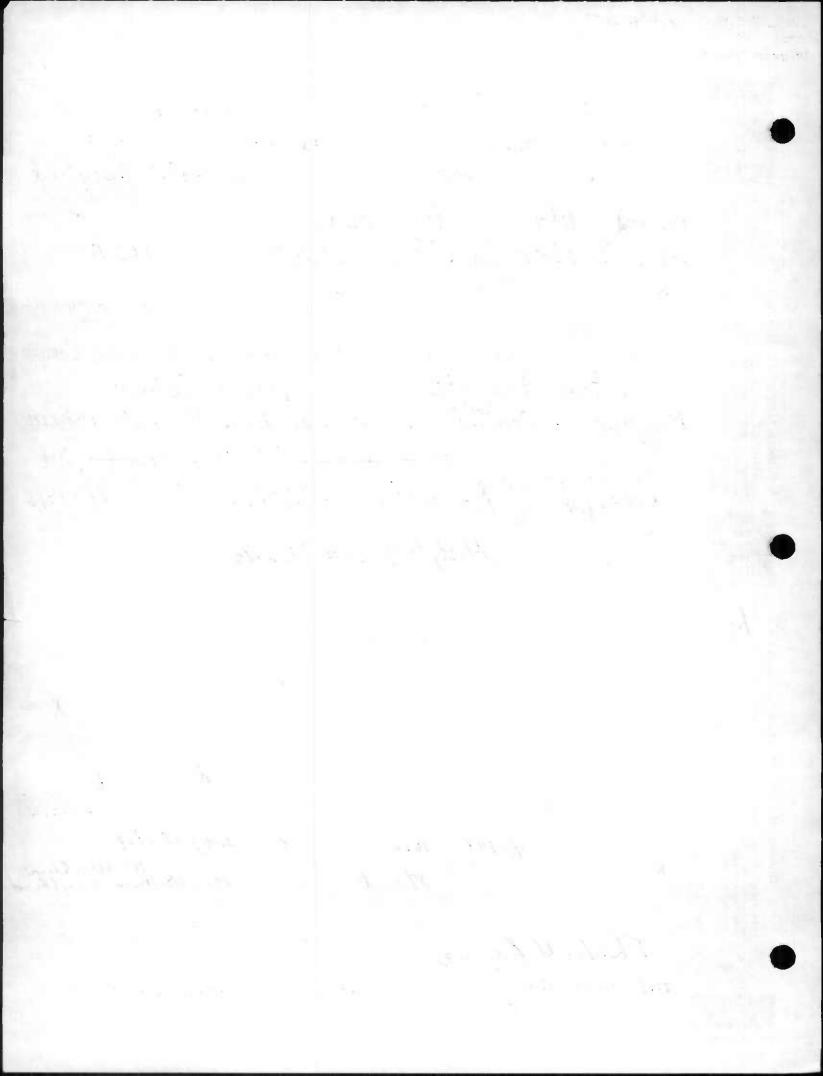


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nald N. Cole	es n#20b.20c per FH G763 9/	State of Maryland / Depart	ficate of Death	Reg. No.	27/26
Physician	1. Decedant's Nama (First, Middla, Las			2 Date of Death Month Day September 02, 1	3. Time of Death 998 4:55 P.M.
/Medical Examiner	4a Fecility Name (If not institution, give	street and number)		Location of Death 4c. County of	10000
,	1600 Block of Clo		Baltimor Under 1 Year If Under 24 Hrs		M/H
Funeral Director	5. Social Security Number 6. S 214-92-2450 Usual Rasidanca of Decedant		onths Days Hours Min	8. Dala of Birth Month, Day, Year 772	9. Birthplaca (Stata or Foreign Sountry) Varyland
death with the Maryland ms 23s or 28s-f show murst be notified at neral Director	10e. Stata 10b. County	A Balt	more		10d. Insida City Limits 1XX Yas 2 □ No
ath with the 23a or 28 mat be not	10e. Street and Number 5 Walden	Maple Court	101. Zip Code 21207	10g. Citizan of W	1SA
5 28 5	11. Marital Status 1. Mavar Married 2 ☐ Married 3 ☐ Widowad 4 ☐ Divorced	1 □ Yas 2 □ No	Dacedant of Hispanic Origin? (5 s, specify Cuban, Maxican, Puer Yas 2 No Specify:	Specify Yas or No- to Rican, etc.) 14. Raca Black Appoint:	-American Indian, white, atc. can American
Baltimore, Maryland 21215-0020 semit. Pages 1 and 2 should be filed within 72 hours aft Pagerment of Haalth and Mental Hygiene. mportant: If item 27 is marked other than "natural", or may holury or other traumatic event, the Medical Examination.	15. Decedent's Ed (Specify only highest gra Elamantery/Secondary (0-12)	ucation da completed) College (1-4or 5+) 16a. Decedent (Give kim life. DO)	's Usual Occupation d of work dona during most of wo NOT usa retired	rking 16b. Kind of Bus	te Industry
Maryland 212. Ind 2 should be filed within alth end Mental Hygiene. 27 is marked other than in traumatic event, event,	17. Father's Nama (First, Middla, Last) Barry L.	Carrington	18. Mothar's Na	ma (First, Middla, Maidan Sumama	Coles
Baltimore, Maryland 212 permit. Peges 1 and 2 should be filed withi Department of Haalth and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, traumatic avent, traumatic	19a Informant's Name/Relationship (1	arrington 4902	Chaledon	ural Route Number, City or Town, S	Stata, Zip Code) 4. Md. 21207 City or Town, Slata
Baltimor permit. Peges Deperment of P Important: If ite any Injury or of	1 Description 2 Cramation 3 Cramation 3 Cramation 4 Connection 5 Cother (Spacification 5 Cramation 5 Cramation 5 Cramatication 5 Cramatica	Ramoval from Stata cametary, ciemate	ony or other place, Mt Zion ame and Address of Facility	(1) at 1.	sdownelle, Md.
Balt. Permit. Departimental	1 Jaseph	L. Kuss Jos	eph L. Rus	& Funeral to	tome Md. 21216 Approximata
Physician // // // // // // // // // // // // //	Immediata Causa (Final disaasa or condition	plications that caused the deeth. Do not anter to one ceuse on each line.	1+ Un of		Interval Batwaan Onsat and Death
Examiner b	resulting in death)	Due to (or as a consequent	nce of):		
(68760, ortificete be associted ing physician and ses the burial-transit Medical Examiner		Dua to (or as a consequer Dua to (or es e consequer			
Box (eath certification)		d			
cords, P.O. Box v requires thet the death cert been signed by the ettending should be deteched for use a		ontributing to death but not resulting in the unde	rlying causa givan in Part I.		tributa to the cause of death? 3 Probably 4 Unknown
al Records, The law requires the cate has been signe, page 2 should be completed by				24a. Was an autopsy performed?	24b. Wara autopsy findings available prior to completion of cause of death?
The lay page 2				1 Yas 2□ No	1 Yas 2□ No
Vital Incention of the contilicate inactor, page Co	25. Was case rafarrad to medical axaminar?	Hospital:	Other	ath (Check only ona)	- M-
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death certificate hours after death. To the Funeral Director: After this certificate has been signed by the ettending completely filled in by the funeral director, page 2 should be datached for use a Medical Certification: To Be Completed by Physician/M	1 X Yas 2 No 27. Mannar of Daath 1 Naturel 5 Panding 2 Accident invastigation	28a. Data of Injury (Month, Day Year) 28b. Tima of Injury	3 DOA 4 Nursing 28c. Injury at Work? M 1 Yas 2 No	Home 5 ☐ Rasidance 6次Otha 28d. Dascribe Aqw injury occurre	
Division C To the Hospital or Attending P within 24 hours elter death. To the Funeral Director: After t completely filled in by the funeral Medical Certification:	3 Suicida 6 Could not be datermined	28a. Place of Injury - At homa, farm, straat building, etc. (Specify)	factory, offica	28f. Location (Street and Number City or Town, Stata)	or or Rural Routa Number, on the Charles Stender
To the Hospital within 24 hours of To the Funeral I completely filled	29a. Cartifiar 1 ☐ Certifying Ph (Check only one) 2 ☑ Medical Exam	/alcian: To the best of my knowledge, death or liner: On the basis of examination and/or invest and manner stated.	curred at tha tima, data and plac igation, in my opinion, daath occ	a, and dua to the cause(s) and ma urred at tha tima, data end placa, a	nnames stated. and dua to the cause(s)
To the comple	29b. Signatura and title of certifier	1/2/	29c. Licensa number O.C.M.E.		(Month, Day, Year)
2	30. Nama and addrass of person who	completed cause of beath (Item 23a) (Type, Pri		Baltimore, Maryl	land 21201
State Registrar	31. Data filed (Month, Day, Year)	32, Registra's Signatura	Sparks		



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crn Unknown 98-189	State of Maryland / Department of Health and M	
	20b 20c per FH G763 9/15/98 FW Certificate of Death	Reg. No.
Physician	1. Decedent's Name (First, Middle, Last)	Dete of Death Month Dey
/Medical	4a Fecility Name (If not Institution, give street end number) 4b. City, Town, or Lo	September 02, 1998 4:55 P.M. cation of Deeth 4c. County of Deeth
Examiner	1600 Block Clough Street Baltimore	A// A
Funeral Director	5. Sociel Security Number 6. Sex 11 M 2 F 7. Age (In yrs. lest birthday) Yrs. 12 Months Deys Hours Min.	8. Date of Birth (Moeth, psy. Year) 7 Nary and
eryland show	Usuel Residence of Decedent 10e. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
the M	Maryland NA Baltimore 10e. Street and Number 10f. Zip Code	1 Ves 2 No 10g. Citizen of Whet Country?
th with	2113 Tucker Lane C-3 21207	USA
Remarkant Programmer P	11. Marital Stetus 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specific Yes, specify Cuban, Mexican, Puerto	cify Yes or No- Rican, etc.) 14. Rece - American Indian, Biack, White, etc.
D20 urs efter efte	1 Never Married 2 Married 1 Yes 2 No Hyes, Give 1 Yes 2 No Specify: Yeer or Detes:	African American
21215-0020 d within 72 hours of piens. or then 'neturel', or the Mourcel Exert.	15. Decadent's Education 16e. Decedent's Usuel Occupation (Specify only highest grede completed) (Give kind of work done during most of worki	16b. Kind of Business/Industry
1 21215-0 led within 72 ho yogiene. The Mexical It the Mexical Completed	Elementery/Secondery (0-12) College (1-4or 5+) life. DO NOT use retired)	Hor Private Company
and 2 be filed tiel Hygi d other event, tr	17. Fether's Neme (First, Middle, Last) / Last 18. Mother's Neme	(First, Middle, Melden Sumeme)
2 2 5 4 9 m	Burton lisdale April	L. Cohens
Maryla nd 2 should sith and Men 27 is marks r traumatic	19a. Informent's Name/Reletionship (Type, Print) (mother) 19b. Mailing Address (Street end Number or Rura Mrs Anri 1. Cohens 2113 Tucker La	n Part Route Number, City or Town, State, Zip Code)
os 1 and of Heelth	20a. Method of Disposition 20b. Plece of Disposition (Name of complete property or other place)	Date, 20c. Location - City or Town, Stele
Baltimore,	1 Buriei 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify)	10/98 Catonsville, Md.
Ball Sepant Meny Inj	21. Signature of Furneral Service Loansee 22. Name and Address of Sociity Doseph L. KUSS,	Funeral Home
	2222 W, North	Ave. Balto, Md. 2/2/6 or respiretory errest. Approximate
Physician	23a. Part / Enler the distance or completitions that caused the death. Do not enter the mode of dying, such as cardiac or shoet or heart failure. List only one cardiac on each line.	intervel Between Onset and Death
/Medical Examiner	Immediate Couse (Final disease or condition a. Multiple Junchof World World Final disease or condition as Multiple Junchof World World Final disease or condition as Multiple Junchof World Final disease or condition as Multiple Final disease or condition as Multiple Final disease or condition as Associated Associated Associated Associated Associated Associated Associated Associated Associated Associat	18
- I	Due to (or es e consequence of):	
cuted in transit	Sequentially list conditions, Due to (or es e consequence of):	
60, be exempled at Ex	If eny, leading to immediate cause. Enter Underlying Couse (Disease or injury c	=
68760, tificate be exerging a physicial a as the burier.	that initiated events Due to (or es a consequence of): resulting in deeth) Lest	
P.O. Box 68760, nat the death certificate be exert the death certificate be exerted by the attending physicial of the bunk.	d	
P.O. B. hat the death do by the atte deteched for	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.	23b. Did tobacco use contributa to the cause of death?
P. P. that the that the head by a detact		1 Yes 2 No 3 Probably 4 Onknown
Division of Vital Records, P.O. for Attending Physician: The lew requires that the da after death. Director: After this certificate has been signed by the a in by the funeral director, page 2 should be detached extification: To Be Completed by Physic		24a. Wes en eutopsy performed? 24b. Were eutopsy findings eveilable prior to completion of cause
Recolumn has by ge 2 st		of deeth?
in: Thu Ifficate or, pag	25. Was case referred to medical 26. Place of Deett	Yes 2 No 1 Yes 2 No
of Vita hysician: his certifical al director	examiner?	me 5□ Residence 6 Mother (Specify) at SCENE
On O	1 Naturel 5 Pending Month, Dey Year) Injury Work?	28d. Describe how Injury occurred
/isic Attend r death r	2 Accident	28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 1600 6000 Local
Div tal or al Div led in I	4 Homicide building, etc. (Specify)	Strut Baltinge Mary land
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The lew requires that the death certificate be examinin 24 hours after death. Within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physiciarly a completely filled in by the funeral director, page 2 should be detached for use as the buritak. Medical Certification: To Be Completed by Physiciar/Medical Ex	29a. Certifier (Check only one) 1 Certifying Phyeician: To the best of my knowledge, death occurred et the time, date end place, to the basis of examinetion end/or investigetion, in my opinion, deeth occurred and manner stated.	end due to the ceuse(s) and menner es steted. ed et the time, date end place, end due to the ceuse(s)
To the vithin To the comple	29b. Signature and title of certifier 29c. License number	29d. Dete signed (Month, Day, Year)
● <i>b</i> /	Theoline U. La wa	September 03, 1998
X	30. Name end eddress of person who completed cashs of death (Tiem 23e) (Type, Print)	
State	31. Date tiled (Month, Day, Yeer)	altimore, Maryland 21201
Registrar	SEP 0 4 1998 B. Apacks	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** CRAIGHEAD MARGARETTE LOVELYN /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Fecility Name (If not institution, give street end number) Examiner ANNE ARUNDEL NORTH ARUNDEL HOSPITAL GLEN BURNIE If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Dey, Year) 5 Social Security Number If Under 1 Year Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1□ M 2√ F Months Days 242-28-0218 89 Yrs. JAN. 8, 1909 VIRGINIA Director Usuel Residence of Decedent the Maryland 10e State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 21 No Director MARYLAND ANNE ARUNDEL ODENTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ? is marked other than "natural", or flems 23a or traumatic event, the Medical Examiner must be a 72 hours after death with P.O. BOX 23 21113 II.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yas, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritel Status Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married SpecifyWHITE 1 Yas 2 No Specify: þ 3 XWidowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within sent of Haalth and Mental Hygiene. Collaga (1-4or 5+) Elamentary/Sacondary (0-12) N/A CIVIL SERVANT WORKER FORT MEADE 17. Father's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) **JASPER** LEMUEL STOVER ELIZA SLUSHER 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Coda) 19a. informent's Neme/Ralationship (Type, Print) JAMES CRAIGHEAD (SON) 508 MADINGLEY ROAD, LINTHICUM, MD. 21090 27 20e. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other piece) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Crametion 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) = 0 EPIPHANY CEMETERY 9/2/98 ODENTON, MARYLAND 21. Signature of Funeral Service Licenses 22. Name end Address of Facility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 23e. Pert1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one cause on each line. Approximete Intarval Between Onset and Deeth Reviewed by AA COME **Physician** /Medical Immediata Causa (Final disease or condition resulting in death) Examiner Physician/Medical Examiner Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Causa (Disaasa or injury that initiated events resulting in deeth) Lest and Division of Vital Records, P.O. Box 68760 the death cartificate be Due to (or as a consequence of): Sa signed by the a d be datached f Part II. Other afgniffcant conditions contributing to death but not resulting in the underlying causa givan in Part f. 23b. Did tobacco use contribute to the cause of death? fracture left femur 1 Yes 2 No 3 Probably 4 Unknown p 24b. Wara autopsy findings available prior to completion of cause of death? 24e. Was en eutopsy performed? Completed cartificate has b The 1 Yes 2 No 1 TYPE 2 NO or Attending Physician: director, 25. Was case raferrad to medical 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA this funarai 28a. Date of Injury (Month, Day Year) Certification: 27. Mannar of Death 28b. Tima of 28d. Describe how Injury occurred 28c. Injury et Work? Twistny 1 Natural Injury 5 Pending left Knee 2 No injum to angus 22 1998 9:00 AM 1 Yes investigation 2 Accident Director 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Numbar or Rural Route Number, City or Town, Stete) 4 Homicide NUNSING Home 24 hours 1 Cartifying Physician: To the bast of my knowledge, death occurred at the time, date and plece, end due to the ceuse(s) and manner es stated. 29a. Certifier edical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred of the time, date end place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29b. Signature end title of certifies 29c. License number 29d. Date signed (Month, Dev. Year)

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Registrar

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32. Registrak Signatura

30. Name and address of person who completed causa of daath (Itam 23e) (Type, Print)

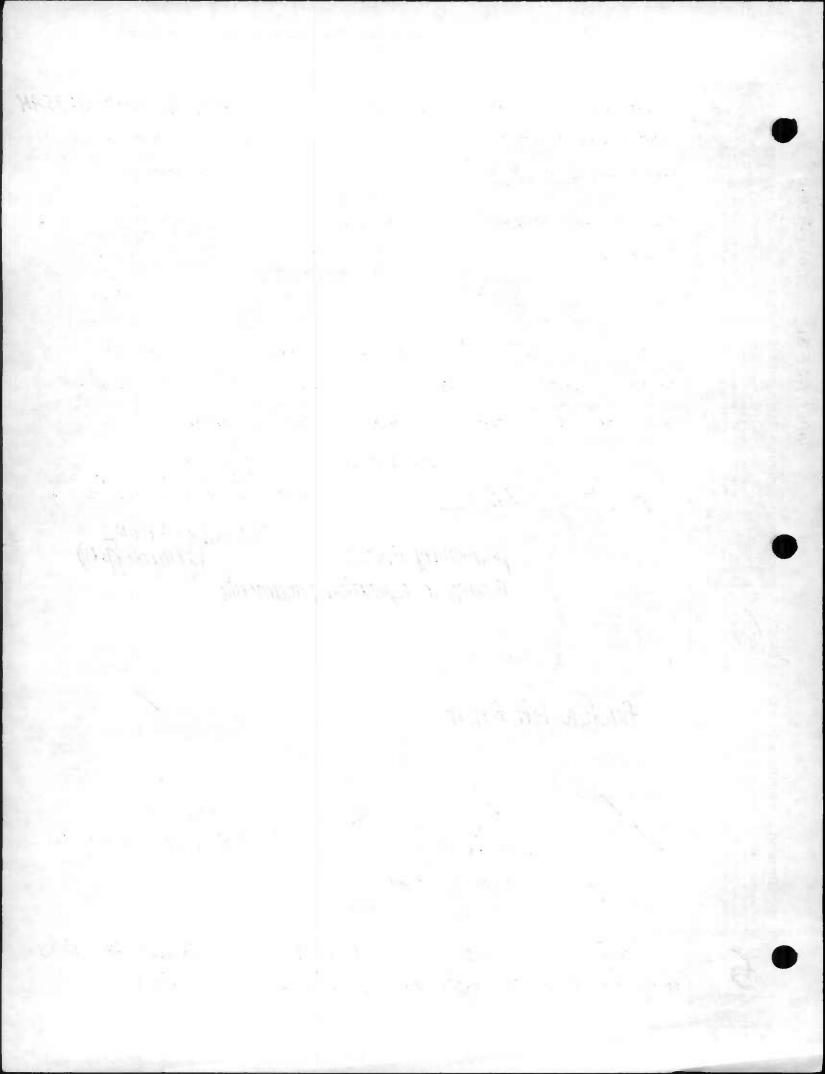
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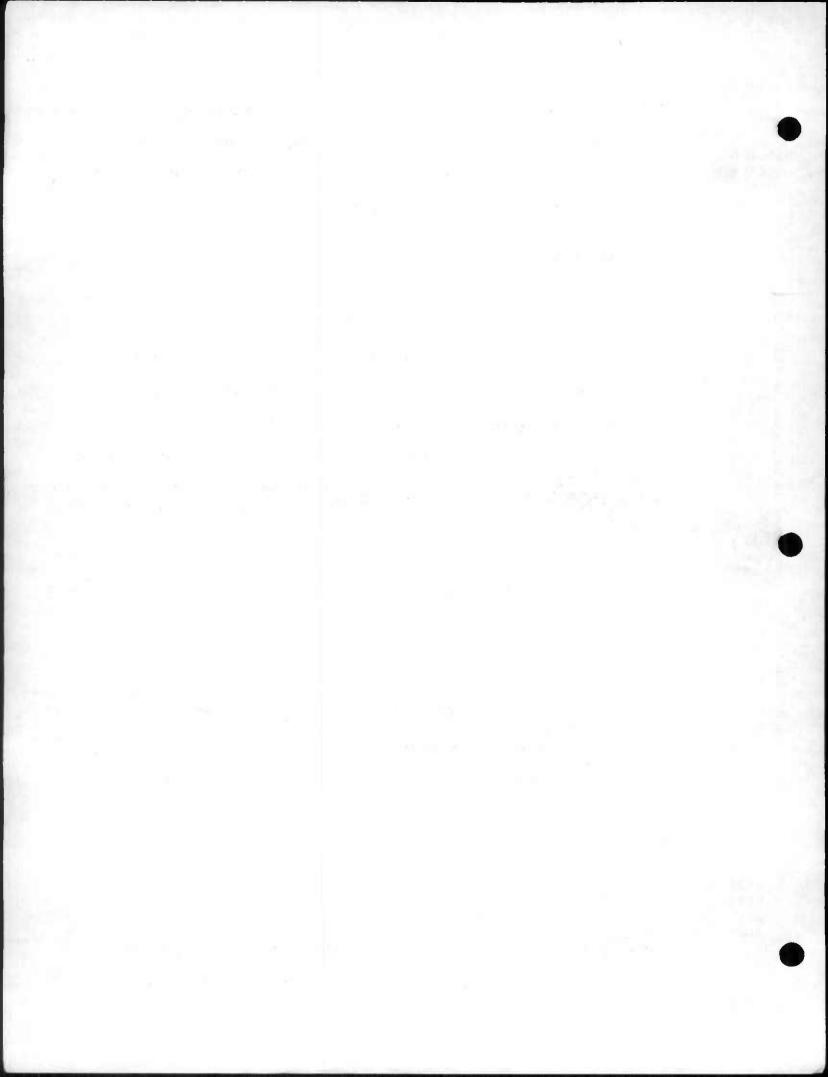
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Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Defe of Deeth 49 Month SEP RICHETTA Oi 224 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth 64FRANKLIN ST ANNAPULLIS Mel If Under 1 Year | If Under 24 Hrs. 8. Defe of Birth (Month, Dey, Yeer) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthdey) 1□ M 25 F Months Deys Hours 504-18-0468 74 DEC South Dakota Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Meade Sturgis 1 Yes No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 2020 Park Avenue 57785 USA 12. Wes Decedenf Ever in U,S. Armed Forces? 1 ☐ Yes 2☐ No If Yes, Give X Yeer or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 Never Married 2 Married 1 Yes X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondery (0-12) College (1-4or 5+) Homemaker Domestic 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) Roy S. Ness Blanche Brink 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Annapolis, MD 214 Date 20c. Location - City or Town, State 21401 Marcia L. Geaglone/daughter 1656 Tim Tam Ct. 20b. Place of Disposition (Name of cemetery, cremetory or other placa) 20e. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State Metro Crematory, Inc. 9/2/98 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service I 22. Name end Address of Fecility Dawn F. McDonald Cremation Society of Maryland, Inc. Dawn F. McDonald 299 Frederick Rd. Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart fellure. List only one cause on each line. Approximete Intervel Between Onset and Deeth Immediate Ceuse (Finel disease or condition resulting in deeth) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lest Due to (or es e consequence of Due to (or as e consequence of) 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Perty 3 Probably 4 Unknown 1 Yes 2 No of 24b. Were eutopsy findings aveilable prior to completion of cause of deeth? 24e. Wes en eutopsy 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 28. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

Physician /Medical Examiner

Physician

/Medical

Examiner

10e. State

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Funeral

Director

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2 should be filed within 72 and Mental Hygiena.

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Department of Health and N. Important if Hem 27 is meany injury or other

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72 hours after

Baltimore, Maryland 21215-0020

Box 68760

Division of Vital Records, P.O.

Director

Funeral

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Completed

Examiner Physician/Medicai þ 8 Completed diractor, Be P Certification:

this funeral After To the Mospital or Attending within 24 hours after death.

To the Funerel Director: After p

25. Wes case referred to medical exeminer? 1 | Yes 2 | ₽o

27. Menner of Death 1-Nefurel 5 Pending investigation 2 Accident

6 Could not be determined 3 ☐ Sulcide 4 - Homicide

Dete of Injury (Month, Dey Year) 28b. Time of

28e. Plece of Injury - Af home, ferm, streef, factory, office building, etc. (Specify)

28c. Injury et Work?

28d. Describe how injury occurred

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) Cartifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture and title of certifier

29a. Certifier

(Check only one)

29c. License number DW21438

1 Yes 2 No

29d. Date signed (Month, Dey, Year)

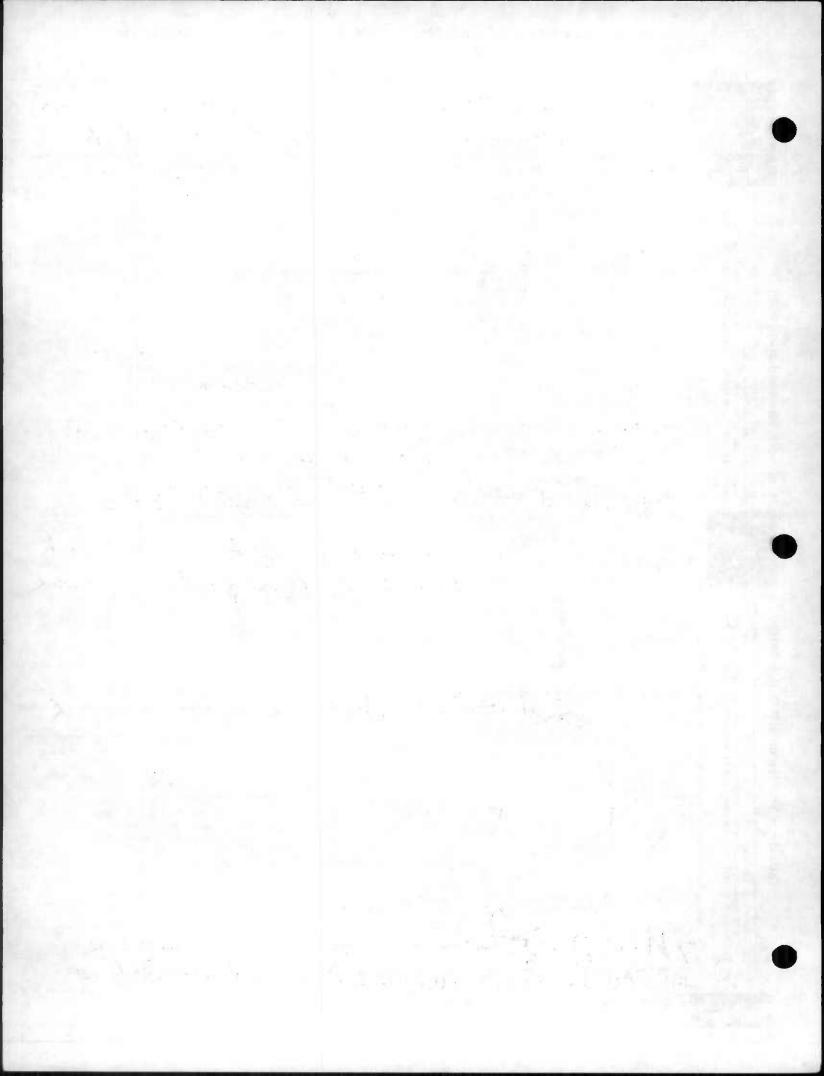
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State Registrar

Medical

31. Date filed (Month, Day, Year) 4 32. Registrer's Signeture

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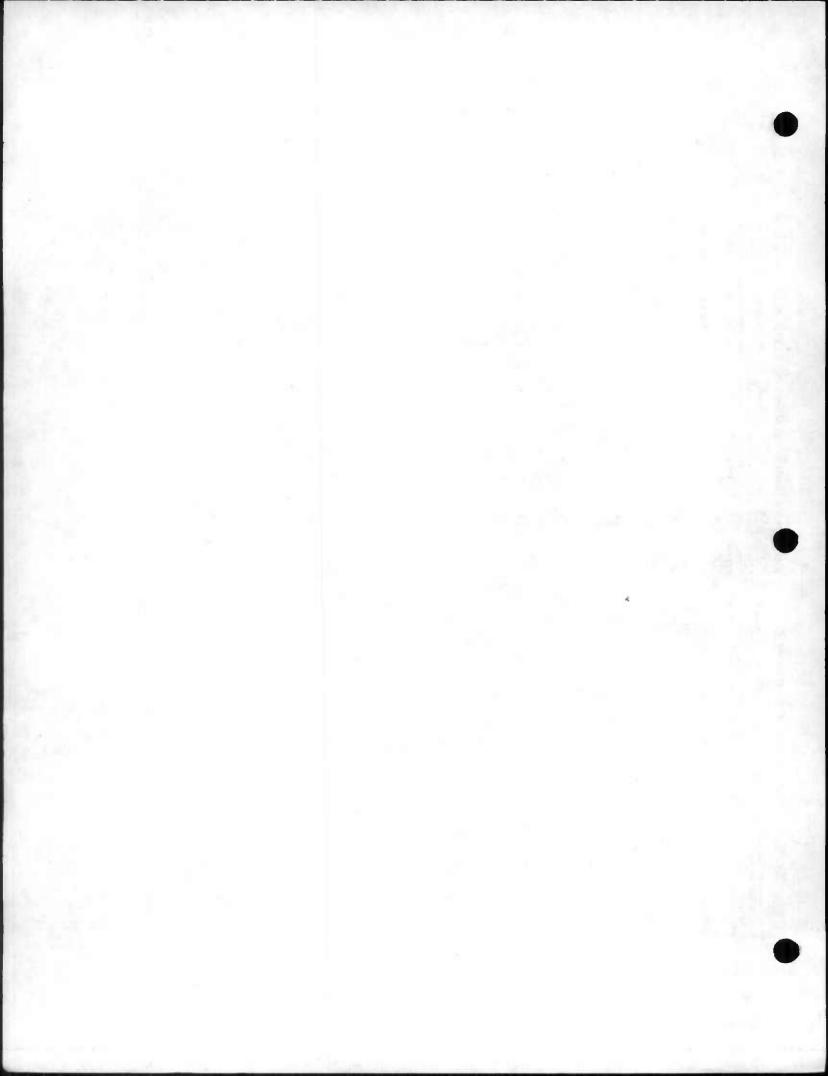


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State of Maryland / Department of Health and Mental Hygiene

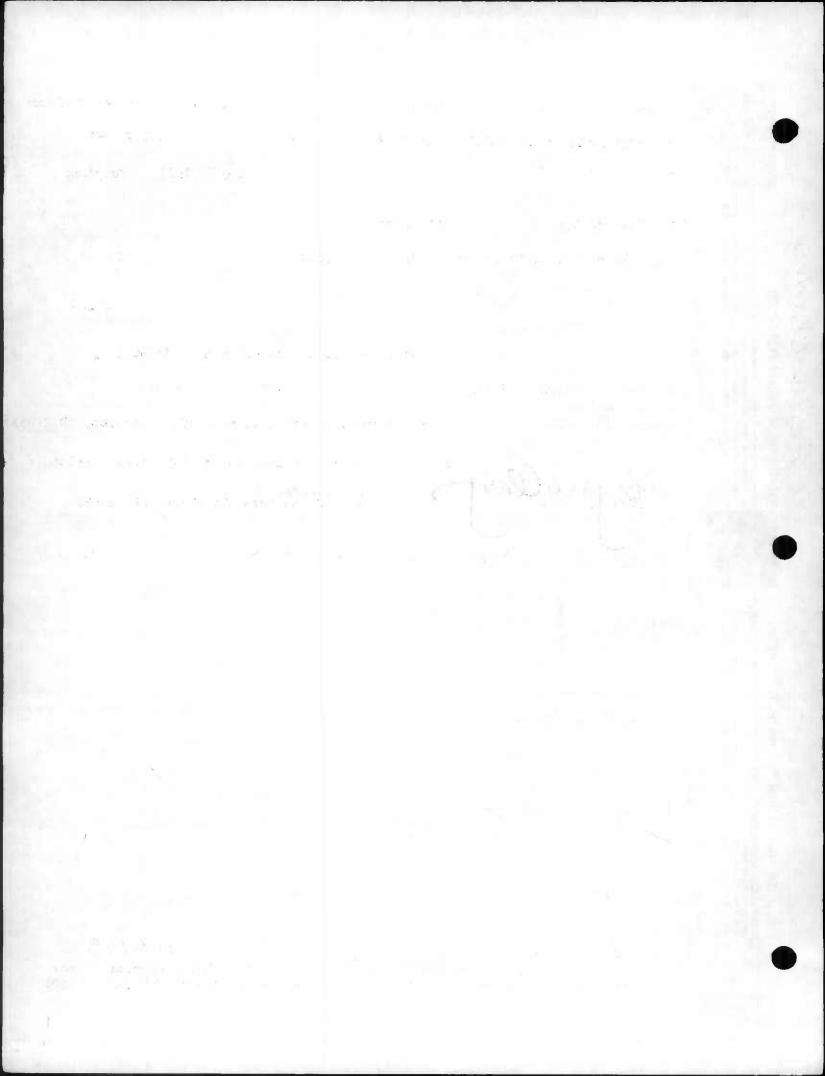
				Certi	ficate of	Death		Reg. No.	21	132
Physician	1. Decedent's Name (First, Min						2. Date of De Month	ath Dey		. Time of Death
/Medical			l. L. F	arring			August		190	8:15am
Examiner	4a Facility Name (If not institu		er)				or Location of Deat	,	of Deeth	
	1439 Winston 5. Social Security Number	Avenue 7.	Age (In yrs. las	t hirthday)	If Under 1 Year	Balti Hunder 24 H	more rs. 8. Date of Bir	N/A	9 Rintholace	(Stete or Foreign
uneral irector	240-42-4072 Usual Residence of Decedent	10 M 2□ F	66		Months Days	Hours M		-1931	Country	N.C.
111	10a. State 10b. Cour	nty	10c. City, 1	own or Loca	tion				10d.	Inside City Limits
be notfiled at Director	Md N	/A	Bal	timore	9					Yes 2□ No
I Directo	10e. Street and Number 1439 Winston	Avenue			10f. Zip Code 21239)		10g. Citizen of 1		
by Funeral C	11. Marital Status 1 Never Married 20 M 3 Widowed 4 Divorce	If Yes Give	es? XNo		is Decedent of H 'es, specify Cub	lispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or No erto Rican, etc.)	Specify	be - American lick, White, etc. Blac	
pet	15. Deced	lent's Education hest grade completed)	1	6a. Deceder	nt's Usual Occup	pation during most of v	work in a	16b. Kind of B	usiness/Industr	ry
Completed	Elementary/Secondary (0-12 9th grade		or 5+)	lile. DC	Laborer	d)	voiking	Synf	ax N.J	
Bec	17. Father's Name (First, Midd	le, Last)				18. Mother's N	lame (First, Middle	, Maiden Suman	ne)	1-17
2	Willie I. Blu	e Farringtor	1			Martha	Cooper			
	19a. Informant's Name/Relation	onship (Type, Print)		19b. Mailing	Address (Street	and Number or	Rural Route Numb	er, City or Town,	Stete, Zip Cod	de)
	Gloria Fairfa	x- Niece				d Drive	Baltimo	re, Md 2	21212	
	20a. Method of Disposition XIX Burial 2 ☐ Cremetio 4 ☐ Donation 5 ☐ Other				ion (Name of tory or other ple emorial	Garden	9-4-98	Baltimo		
	21. Signature of Funeral Servi			22.1	March F	ss of Fecility /H West	t			
	23a: Part1. Enfor the disease,	March					Avenue B		e, Md 2	1215
s the buriel-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	6	Due to (or as						1	
Physician/Me	Part II. Other algnificant cond	ditions contributing to death	h but not resultir	ng in the und	erlying cause giv	ven in Pert I.	23b. Did	tobacco use co	ntribute to the	cause of death?
by Ph	alceholic	dement	a		200		_ 1□	Yes 2□No	3 Probabl	y 4 Unknow
Completed by Physic								an autopsy ormed?	availat	eutopsy findings ole prior to etion of cause th?
Mo							10	Yes 2500	1 □ Ye	s 200 No
Be	25. Was case referred to medi examiner?					26. Place of E	Deeth (Check only	one)		
10	1 Yes 2DTNo	Hospital: 1 Inpo	atient 2 ER	/Outpatient	3□ DOA Oth	ner: 4 Nursing	Home 5 Bes	idence 6 Oth	ner (Specify)	
Certification:	3 Suicide 6 Cou	stigation Id not be mined 28e. Place of	Injury - At home etc. (Specify)	tb. Time of tnjury o, farm, stree		y at rk? Yes 2 □ No	28f. Location	how injury occur Street and Numl wn, State)		oute Number,
Ical Certification: T	(Check only 2 Medic	ying Physician: To the be al Examiner: On the basis	s of examination	dge, death o	ccurred at the til	me, date end pla	tce, and due to the courred at the time,	cause(s) and modate and plece,	enner es stated	d. cause(s)
Medical Certi	one) 29b. Signature and title of certi	and manner	stated.		29c. Licens	se number		29d. Date signe	d (Month Dev	Year)
	2.50. Signature and tale or carr	110	17 33					Lou. Date signe	1111	. 4
,	,	/ leg	ans			6197		9	1319	8
)	30. Name and address of personal Milvard	1 -	of death (Item 23			c onio	e, Bulh	me, h	15 an	211
State gistrar	31. Date filed (Month, Day, Yea SEP 4 199		istrar's Signature	1	0.1		,			

DHMH 16 Rev 6/95



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	Certificate of Death		Reg. No.		
Physician	1. Decedent's Nama (First, Middla, Last)	2. Data of Do Month		3. Tima of Death	
dical	Charles Henry Feihe	AUGU:	ST 30 1	998 7:40pm	
niner		n, or Location of Dear	1		
	GREATER BALTIMORE MEDICAL CENTER TOWSO	ON	BALT	IMORE	
	5. Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) If Undar 1 Yaar If Undar 24 Months Days Hours	4 Hrs. 8. Data of Bi Min. (Month, D	rth av. Year)	Birthplaca (Stata or Foraign Country)	
	216-03-2147 1\(\overline{\text{X}}\text{M}\) 2□ F 77 Yrs. Months Days Hours	Aug 7,	1921	Maryland	
	Usual Rasidance of Decedant			Table to the Other Limite	_
	10a. Stata 10b. County 10c. City, Town or Location			10d. Insida City Limits 1 ☐ Yas 2 🔀 No	
oto	Maryland Baltimore Timonium				
Directo	10e. Street and Number 10f. Zip Coda		10g. Citizan of W	het Country?	
	215 Belmont Forest Court, unit 301 21093			USA	
Funeral	11. Marital Status 12. Was Decadant Evar in U,S. Armed Forcas? 13. Was Dacedant of Hispanic Origin If Yas, specify Cuban, Maxican,	in? (Specify Yas or N Puarto Rican, atc.)	0- 14. Race Black	- Amarican Indian, k, Whita, atc.	
	1 ☐ Navar Marriad 2 ☑ Married 1 ☐ Yas 2 ☑ No II Yas 2 ☑ No Specify:		Specify:		
d by	3 ☐ Widowed 4 ☐ Divorced Yaar or Datas:			White	_
Completed	15. Decedant's Education 16a. Decedant's Usual Occupation (Specify only highast grada complated) (Giva kind of work dona during most of the complated)	of working	16b. Kind of Bus	sinass/Industry	
Idm	Elementery/Secondary (0-12) College (1-4or 5+)				
	12 4 Certified Public Acc		Accou		_
Be		's Nema (First, Middle			
5		stasia	McGann		
	19a. Informant's Name/Ralationship (Type, Pnnt) 19b. Meiling Address (Street and Number				
	Frances Feihe/Wife 215 Belmont Forest				3
	20a. Mathod of Disposition 1 X Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 20b. Place of Disposition (Nama of cemefary, cramatory or other place)	Data	20c. Location - (City or Town, Stata	
	4 □ Donation 5 □ Other (Specify) Dulaney Valley Mem. Grd	ns.9/3/98	Timoniu	m, Maryland	
	21. Signature of Funaral Servica Libenson 22. Nama and Addrass of Facility	**			
	Lemmon Funeral 10 W. Padonia		nium, MD	21093	
	23a. Part I. Efter the disaasa, or complications that causal tha death. Do not anter the mode of dying, such as causal the death in ura. List only one cause on each in a.			Approximete Intarval Batween	
n l	should be maint injura. List only one cause of accit pla.			Onsat and Daath	
	Immediata Cause (Final disaasa or condition and and Infancial Infa	~~		17.64	
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ner					
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an/Me	d				
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hys			Yae 2 No	3 Probably 4 Unknown	1
by P	Leval failure				
D.		24e. Wa	s an autopsy	24b. Were autopsy findings available prior to	
Completed		per	ormad?	complation of causa of death?	
gmc			Yas 22 No	1 ☐ Yes 2 ☐ No	
	25. Was casa rafarrad to medical 26. Place of			1 183 ZU NO	
De	axaminar? Hospital: Other:	of Daath (Chack only		(04-)	-
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ion	Natural 5 Panding (Month, Day Year) Injury Work?	- N			
icat	3 Sulcida 6 Could not be		(Street and Numb	er or Rural Routa Number,	_
THE	4 Homlcide 28a. Placa of Injury - At homa, farm, straat, factory, offica building, etc. (Specify)		own, Stata)		
edical Certification:	000 004#20 4 60 4#11 50 4#11				_
lica	29a. Cartifiar (Check only 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death	place, and dua to the occurred et the time	causa(s) and ma , data and place, e	nnar as statad. and due to the ceuse(s)	
Med	one) and mannar stated. 29b. Signatura and title of certifier 29c. Licansa number		29d Data sinned	I (Month, Day, Year)	
	290. Signatura and thin of common	3/1	200. Data signed	I C Q	
	Marmer no 10185-	7	8/3/	170	
	30. Nama and and was of person who completed causa of death (Itam 23e) (Type, Print)	6701 No	rth Char	les Street	
	Thomas Guannier GBM	Baltimo	re, Mary	1and 21204	
State	31. Data filed (Month, Day, Yaar) 32. Registrar's Signatura				
trar	SEP 0 4 1998 Denus S. sparks				



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State of Maryland / Department of Health and Mental Hygiene

has hell the design	State of Maryla	nd / Department of F Certificate of	Health and Mental Hyg Death	giene 98 27/34
Physician	Decedent's Nama (First, Middla, Last) Charles Donald Farne		2. Data of Dee Month	Dey Year
/Medical	Charles Donald Farne 4a Facility Name (If not Institution, give street and number)		Sept. 4b. City, Town, or Location of Death	1, 1998 4:10PM
Examiner	Greater Baltimore Medical Cen		Baltimore	Baltimore
Funeral		s. lest birthday) If Undar 1 Yaar Months Days	Hours Min. (Month, Da)	9. Birthplace (Stata or Foraign Country)
Director	219-22-9326	Yrs.	March 2	9, 1928 Maryland
land	Usuat Rasidance of Dacedant 10a. Stata 10b. County 10c. C	City, Town or Location		10d. Inside City Limits
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death with the Maryland ms 23a or 28a-f show cross be not fred at	10e. Street and Number	10f. Zip Coda		10g. Citizan of What Country?
ith will	4 Ballycruy Ct. Unit 202	210	093	USA
020 burs efter sal', or ite		if Yes, specify Cub	-Hispanic Origin? (Specify Yes or No- an, Maxican, Puarto Rican, atc.) Specify:	14. Race - American Indian, Bleck, White, etc. Specify: White
iore, Maryland 21215-0020 gas 1 end 2 should be filed within 72 hours ef it of Haelih end Manell Hygiena. It flem 27 is marked other than "natural; or or other traumatic event, the Manina Example To Be Completed by I	15. Decedant's Education (Specify only highest grade complated) Elementery/Secondery (0-12) Collaga (1-4or 5+)	16a. Decedent's Usuai Occu (Give kind of work dona lifa. DO NOT usa retire	during most of working d)	16b. Kind of Businass/Industry Printing
be file thy d other event,	17. Fathar's Name (First, Middle, Last)		18. Mother's Nema (First, Middla,	Meiden Sumema)
ylal ould b Ment Ment ould b M	Charles Thomas Farnen		Blanche Dolor	
Mar 12 sho h end ls me traum	19a. Informent's Neme/Retationship (Type, Print)		t and Numbar or Rurel Route Number	
tael tael	Patricia A. Farnen/Wife 20a. Mathod of Disposition 20b.	Place of Disposition (Nama of	St. Unit 202 Timo	20c. Location - City or Town, State
ages ant of tr: If It y or o	A Novice 2 Comption 2 Demovative State	cemetary, crematory or other pla laney Valley Me rdens		Timonium
Baltimore, Mc permit. Pages 1 end 2 a Department of Health en Important: If liem 27 is any injury or other trau page.	21. Signature of June Sal Co Densee	22 Nama and Addrs	ass of Facility	
Depariment impos	Nichael Plagle		eral Home of Dul onia Rd Timonium,	aney Valley, Inc.
Physician /Medical Examiner	b. Due to	OTO PULMO (or as a consaquanca of):	NART A	Interval Betwaen Onsat and Daeth
P.O. Box 68760, at the death certificate be abouted by the attending physician and attached for use as the buriel-hansit Physician/Medical Examiner	if any, laading to immediate cause. Enter Undarlying Cousa (Disease or injury that initieted avents rasulting in daeth) Lest	(or as a consaquance of):		
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	Diabetes, Per	sheral V	accula, "	Yee 2 No 3 Frobably 4 Unknown
aw requires been s 2 should	Disease, Care	leanyop	24a. Was parlo	an autopsy med? 24b. Wara autopsy findings availabla prior to completion of causa of daath?
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Of Vital Physician: Tithis certificate ral director, partial direc	25. Was casa rafarrad to medicat examinar? 1 ☐ Yes 220 to Hospitai: 1 ☐ Inpatiant 2	DER/Outpatient 3 DOA Ot	26. Placa of Deeth (Check only of ther: 4□ Nursing Homa 5□ Resid	
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or Attendant in by the relified	3 Suicida 6 Could not be datamired 28a. Plece of Injury - At building, etc. (Spec	home, farm, straat, factory, offica	28f. Location (3 City or Tox	Streat and Number or Rurel Route Number, vn, Stete)
Dital Division of Ce	29a. Certifier 1 Certifying Physician: To the best of my	neurladge, double equipmed at the t	ima data and piane, and due to the	course(s) and manner as stated
Division of To the Hospital or Attending Phy within 24 hours after deeth. Completely filled in by the funeral Medical Certification: 7	29a. Certifier (Check only 2) Medical Examiner: On the best of my 2 (Check only one) and menner sides.	nation a d/or invastigation, in my	opinion, death occurred et the time,	dete end piece, and due to tha cause(s)
To the vithin To the comple	29b. Signatura and titla of Conflict	29c, Licen	se number	29d. Data signad (Month, Day, Year)
,	A March	KM D.	24564	8/2/98
IXCI		em 23e) (Type Print)	m 01004 5 11 00	
	Alan Shrofsky M.D. 515 Fairmour 31. Data filed (Month, Day, Year) 32. Registrar's Sig		D 21286 Suite 32	.0
State Registrar	SEP 0 4 1998		es)	

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month HELEN August 27,1998 11:09 pm 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Cheverly Prince Georges Prince Georges General Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) Months Days 1□M 2□F Hours 163 26 2967 69 Feb 9,1929 Pennsylvania Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits NOYes 2□No Prince Georges Bowie 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country? 20715 USA 2703 Barberry 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Marital Status Bleck, White, etc. 1 Yes 22No If Yes, Give Year or Dates: 1 Never Married 2 Merried white 1□Yes 2□No Specify: 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Glenn Kelly Lena Sprowels 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Leslie Marie Farrell/daughter 2703 Barberry Lane Bowie Maryland 20715 20b. Place of Disposition (Nama of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State Claysville Cemetery Aug. 31,1998 Claysville, Pa. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility Robert E. Evans Funeral home Inc 16000 Annapolis Rd., Bowie, Md. 20715 23a. Par1. Enter the disease, or complications that shock, or heart failure. List only one cause on Approximete Intervel Between Onset end Deeth Do not enter the mode of dying, such es cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Physician /Medical Examiner

Physician

/Medical

Examiner

Director Md.

Funeral

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Completed

8

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours effer death with the Meryland Department of Health and Meniel Hygiens. Important: If item 27 is marked other than "natural", or frems 23s or 28s-f show eny injury or other treumatic avent, the Medical Exeminer must be nothed.

Baltimore, Maryland 21215-0020

Examiner Physician/Medical à Completed Be Certification: To

To the Hopftal or Attending Physicien: The law requires that the death cartificate be executed within a bours after death.

To the Funeral Director: After this cartificate has been signed by the attending physician and

Division of Vital Records, P.O. Box 68760.

					1
Part II. Other significant conditions o	ontributing to death but not re-	sulting in the underlyin	g cause given in Pert I.	23b. Did tobecco use co 1 ☐ Yes 2 ☐ No	ortribute to the cause of death? 3 □ Probably 4 □ Unknown
				24a. Was an autopsy performed?	24b. Were autopsy findings aveilable prior to completion of cause of death?
				1□ Yes 2♠No	1□ Yes 2No
25. Wes case referred to medical			26. Place of D	eeth (Check only one)	
examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpetient 3	DOA Other: 4 Nursing	Home 5 ☐ Residence 6 ☐ Oth	ner (Specify)
7. Manner of Death 1. Natural 5 Pending 2 Accident investigation		28b. Time of Injury	28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occur	red
3 Suicide 6 Could not b determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, street, fact fy)	ory, office	281. Location (Street and Numb City or Town, Stata)	ber or Rural Route Number,
29a. Certifier (Check only one) Certifying Ph	ysician: To the best of my known inner: On the basis of axamina and manner stated.	owledge, death occurre ation and/or investigati	ed et the tima, data and plac on, in my opinion, deeth occ	ce, and due to the cause(s) and mo curred et the time, data end plece,	enner as stated. end due to the ceuse(s)

29c. License number

29d. Date signed (Month, Day, Year)

General Hospila

State Registrar

Medical

29b. Signature and title of certifie

DHMH 16 Rev 6/95

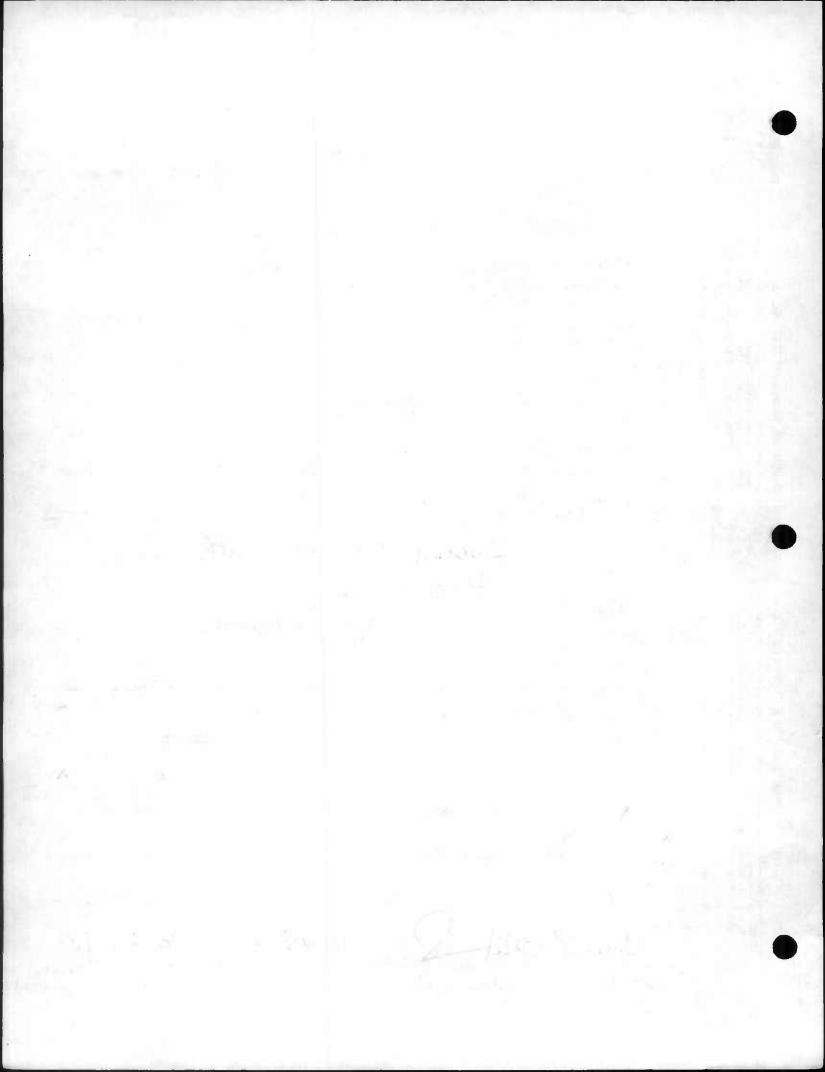
ORIGINAL

of death (Item 23a) (Type, Print)

Pone

sta

Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Death Sept. **Physician** 02 Pay 1998 1:45 PM Edgar Francis Fritsche /Medical 4c. County of Death 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Joseph Medical Center Towson Baltimore Co. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 24, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Months Days Hours 12 M 2□ F 83 1914 Maryland Director 213-07-8267 Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f ahow the Medical Example: must be nothing at 1 Yes 2000 Director Maryland Baltimore Towson 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 105 Overcrest Road 21286 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian. 11 Merital Status Black, White, etc. 72 hours after 1X Yes 2 No If Yes, Give 1 Never Merried 2 Married 1 Yes 2 No Specify: 21215-0020 ò Specify White 3 ☑ Widowed 4 ☐ Divorced WW II Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Elementary/Secondary (0-12) College (1-4or 5+) Shop Foreman Machine Shop Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fill ment of Health and Mental Hant: If Item 27 is marked oth lury or other traumatic even Be John Fritsche Mary Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Mr. Edgar C. Fritsche (Son) 105 Overcrest Road Towson, Maryland 21286 20b. Plece of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 DeBurial 2 Cremation 3 Removal from State Department of important: If any Injury or pose. 4 □ Donation 5 □ Other (Specify) Gardens of Faith Cemetery 9/5/98 Overlea Maryland 21. Signature of Funeral Source Lice 22. Name and Address of Fecility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 ua 23a. Part1. Enter the disease, or/complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Listority one cause on each line. Approximate Interval Betw Onset and Death **Physician** tmmediete Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): physician Box 68760, Due to (or as a consequence of): signed by the attending p Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably 4 Onknown þ Completed 24a. Was an eutopsy performed? 24b. Were eutopsy findings evailable prior to completion of cause of death? should peen page 2 hes 1 Yes 2 DINO 1 ☐ Yes 2 ☐ No certificate of Vital Attending Physician: funeral director. Be 25. Wes cese referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 [Inpatient Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA this 27. Manney of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Division 1 Natural 5 Pending investigation 1 Yes 2 No To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 29a. Certifier 11 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and place, end due to the ceuse(s) end menner es steted. Medical completely (Check only 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and menner stated. 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of dertifie D-19637 88 30. Name and address of person who dempleted cause of death (Item 23a) (Type, Print) Bashar Pharon, M.D.

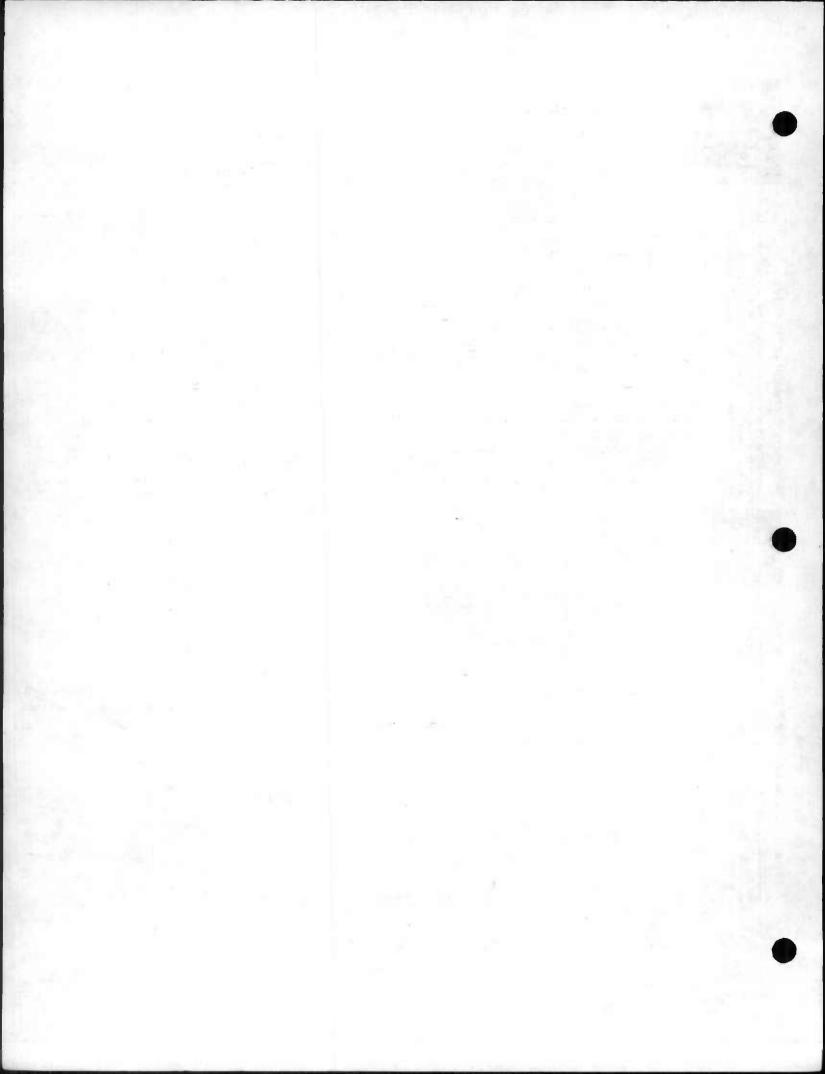
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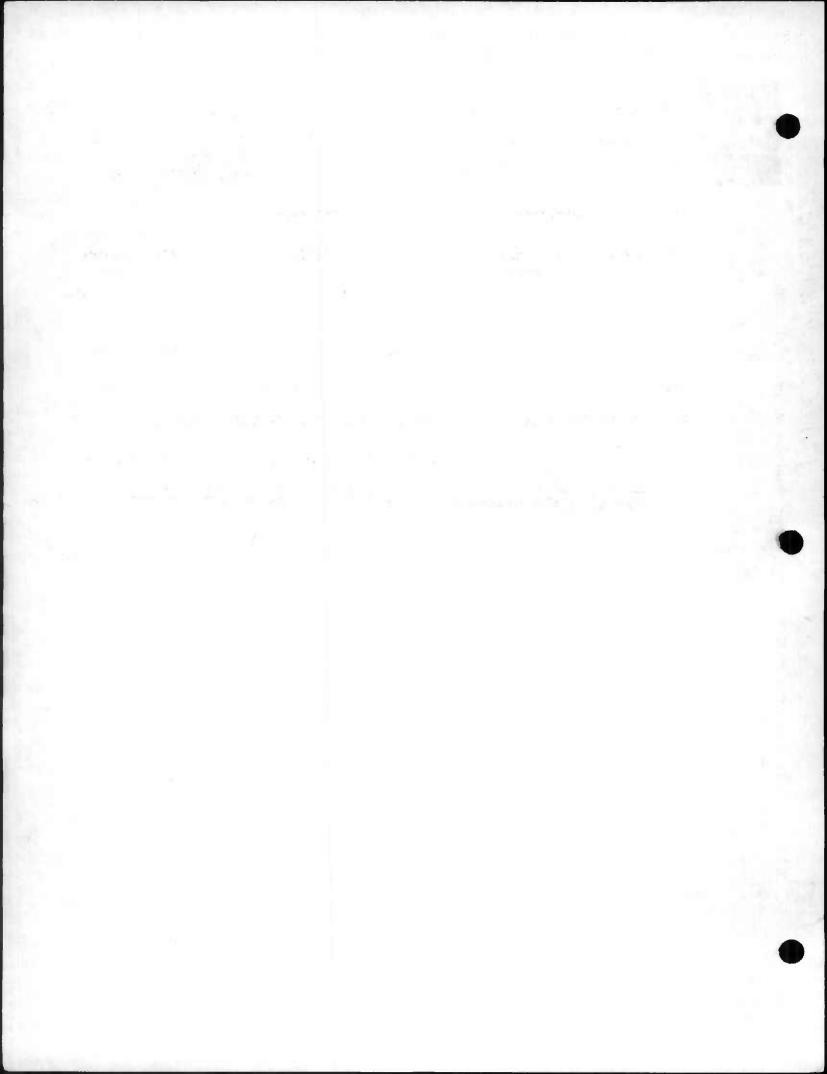
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32. Registrar's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ()

				State of Mary		rtificate of			eg. No.	1. 1.	131
	Physic /Medi		Decedent's Neme (First, Middla, La Lawrence	st) Byron		Fale	s	2. Dete of Deet Month SEDTEM	Dey	Year 1992	Time of Death
	Exami		4a. Fecility Name (If not institution, giv Stella Maris Hos)		У		4b. City, Town, or L Baltimo	ocation of Death	4c. County	ot Deeth	à
	Funeral Director		5. Social Security Number 6. S 212 38 2561	7. Age (In 57	yrs. last birthday) Yrs.	If Under 1 Yaar Months Deys	If Undar 24 Hrs. Hours Min.	8. Data of Birth (Month, Dey, dec. 23	Year) ,1940	9. Birthplece Country)	(State or Foreign
CF	deeth with the Meryland ms 23s or 28s-f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Balt:		c. City, Town or Lo		altimore		, = = = =	10d.	Inside City Llmits 1 ☐ Yes XXNo
3	or 28a	Director	10e. Street and Number			10f. Zlp Code		10	0g. Citizen ot V	Whet Country?	
X	s 23s	erai [2906 Dunmore Rd.	Apt. C	i lia lia		21222			d State	
WREN	15-0020 n 72 hours after deeth with the Meryler "natural", or thems 23a or 28a-f show edical Examiner must be notified at	by Funeral	11. Maritel Status 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever Armed Forces? 1 ☐ Yas 2 No If Yes, Give Yeer or Datas:		was Decedent of Filt Yes, specify Cub 1 ☐ Yes 2\(\tilde{	Hispanic Origin? (Spen, Mexicen, Puarto Specify:	Ricen, etc.)		e - Americen I ck, White, etc. : Wh	nite
KA	Ind 21215-0020 be filed within 72 hours after tal Hygiene. d other than "natural", or he event, the Medical Examine	Completed	15. Decedent's Ec (Specify only highast gra	ducetion de completed) Collaga (1-4or 5+)		dent's Usuel Occup kind of work done DO NOT use retire	pation during most of work d)	sing	16b. Kind of Bu	usiness/Industrution	,
100	other vent,	Be Co	17. Fathar's Name (First, Middla, Last)				18. Mother's Nam	e (First, Middle, M			
(F)	Maryland 212 d 2 should be filed with and Mental Hygiens. T Is marked other than traumatic event, treat	To	James		Fales		Marion			Bentz	
1	end 2 sh end 2 sh eelth and n 27 is m		19a. Intorment's Name/Ralationship (1) Peggy Lee Fales	* * * *			Rd., Apt				de) 21222
FA	D - 1 5 5		20a. Method of Disposition 1 Burial 2 ACremetion 3 4 Donetion 5 Other (Specific	Helliovel Ilolli Stera	Ob. Plece of Dispo camatery, cre	osition (Neme of metory or other ple int Cremat	ce)	Date	20c. Location -		Stete
	Baltimol permit. Pages Depertment of Important: If it any Injury or o		21. Signature of Funeral Service Licen		22	2. Name end Addre		ohrmann	P.A.		
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	Box 6 eeth certifi ettending	ian/N		d							
	15, P.O. res that the derigned by the e	/ Physician/M	Pert II. Other significant conditione of	ontributing to death but not	t resulting In the u	ndarlying ceuse giv	ven in Pert I.		becco use cor	3 Probabl	y 4 Unknown
	Records,	Completed by						24a. Wes er perform	n autopsy ned?	evelleb	autopsy tindings ole prior to ation of cause th?
	The law ate hes page 2	Com						1 ☐ Ye	s 2 No	1 □ Ye	es 2 No
	of Vital Physician: The rthis certificate oral director, pag	o Be	25. Was cese referred to medical examiner?	Hospital:		Oth	28. Place of Deat				1
	On of ding Phys h. After this funeral d	n: To	1 Yes 2 No 27. Manner of Deeth	1 ☐ Inpatiant 28e. Date of Injury (Month, Dey Yea	2 ER/Outpatier 28b. Time of Injury	IL SEL DON	4 LI Nuising Ho	me 5 Reside 28d. Describe ho			tospice
	Division of lor attending Physiater deeth. Director: After this d in by the funeral di	catic	1 Naturel 5 Pending investigation 3 Suicida 6 Could not be			M 1 🗆	Yes 2 □ No				
DR	Division To the Hospital or Attend within 24 hours after deeth To the Funeral Director; completely filled in by the f	Certification:	4 ☐ Homicida determinad	building, etc. (Sp	pacify)			28t. Location (Str City or Town	, Stete)		
Un	To the Hospital within 24 hours a To the Funeral I completely filled	edicai	29a. Certifier (Check only one)	/siclan: To the best of my ilnar: On the basis of exam and mannar stated.	knowladge, deeth ninetion end/or In	occurred et tha tirvastigation, in my o	ma, data end plece, ppinion, daath occur	end due to the ca red et the time, de	usa(s) and me ete end plece, a	nner es steted and dua to the	ceuse(s)
	To th Within	M	29b. Signature end title of certitier	nemo	** >	29c. Licans		25	and Date signed	(Month, Dey,	Year) 1998
	6		30. Neme end address of person who of	completed ceuse of daath		Print) 76	40480 72 3ec	Air RA	esteml 236		-
	Sta	te	31. Dete filed (Month, Day, Year)	32 Registrer's S		1					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend: #29c Per Field Rep - DB Film G763 9-11-98PC Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death Day Month **Physician** 12:15 AM FAHRINGER GLENN 1998 ptember /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death City, 10m.,

Ba / funce

It Under 24 Hrs. 8. Data of Birth
(Month, Day, Year)
Dec. 3, 1945 4c. County of Dyat Examiner chas 1400 11 ta Fahringer If Under 1 Yaar 5. Social Security Number Country) 7. Aga (In yrs. last birthday) 9. **Funeral** 1⊠M 2□ F Months Days Hours Yrs. Pa. 52 Director 174-36-6237 Usual Residence of Decedent v 28a-f show notified at 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 ☒ No Director York York 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 Nerne 23a 17406 USA 4947 Creek Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 🖫 Yes 2 🗆 No If Yas, Giva Year or Datas: Vietnam Was Decedent of Hispanic Origin? (Specify Yes or No If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 7 is marked other than "natural", or her treumstic event, the Medical Examiner 1 Never Married 2 Married 1 □ Yas 2 Ho Specify: Specify: Š 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Precision Component Co. Crane Operator 11 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) Health and Mental Health and Mental Hem 27 Is marked of Wales Fahringer Evelyn Charles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) of Health Item 27 I Mrs. Ursala G. Fahringer/wife 4947 Creek Lane York, Pa. 17406 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, Stata Pages 1 1 ☐ Burial 2 [XCremation 3 ☐ Removal from State 9/3/98 York, Pa. 4 ☐ Donation 5 ☐ Other (Specify) Yorktowne Crematory 22. Nama and Addrass of Facility
Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licer 1050 York Rd. Towson, Md. 21204 Approximata Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediata Cause (Final disease or condition resulting in death) dissection Examiner Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Dua to (or as a consequence of) Box.6876 Physician/Medical that initiated events resulting in death) Last Dua to (or as a consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 8 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 6 Records, ģ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 XNo 1 Yes 2500 of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospitat: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No To 1 Inpatient 2 ER/Outpatient 3 DOA P. 27. Manner of Death 1 2 Natural 28c. Injury at Work? edicai Certification: 28b. Tima of 28d. Describe how injury occurred or Attending F after death. Division Albar 5 Pending investigation Injury after death Director: An d in by the tu 1 ☐ Yas 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be determined 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and mannar stated. 29c. License number P12827 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

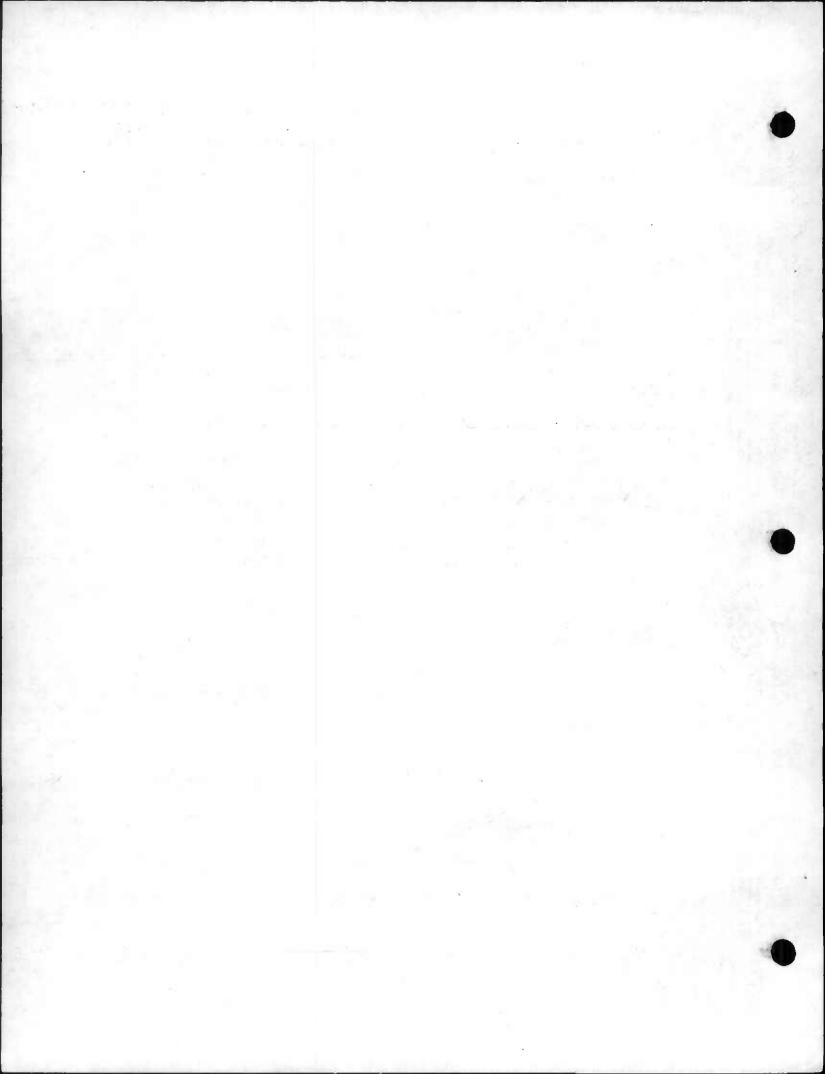
Registrar

31. Data filed (Month, Day, Year)

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32. Registrar's Signatura

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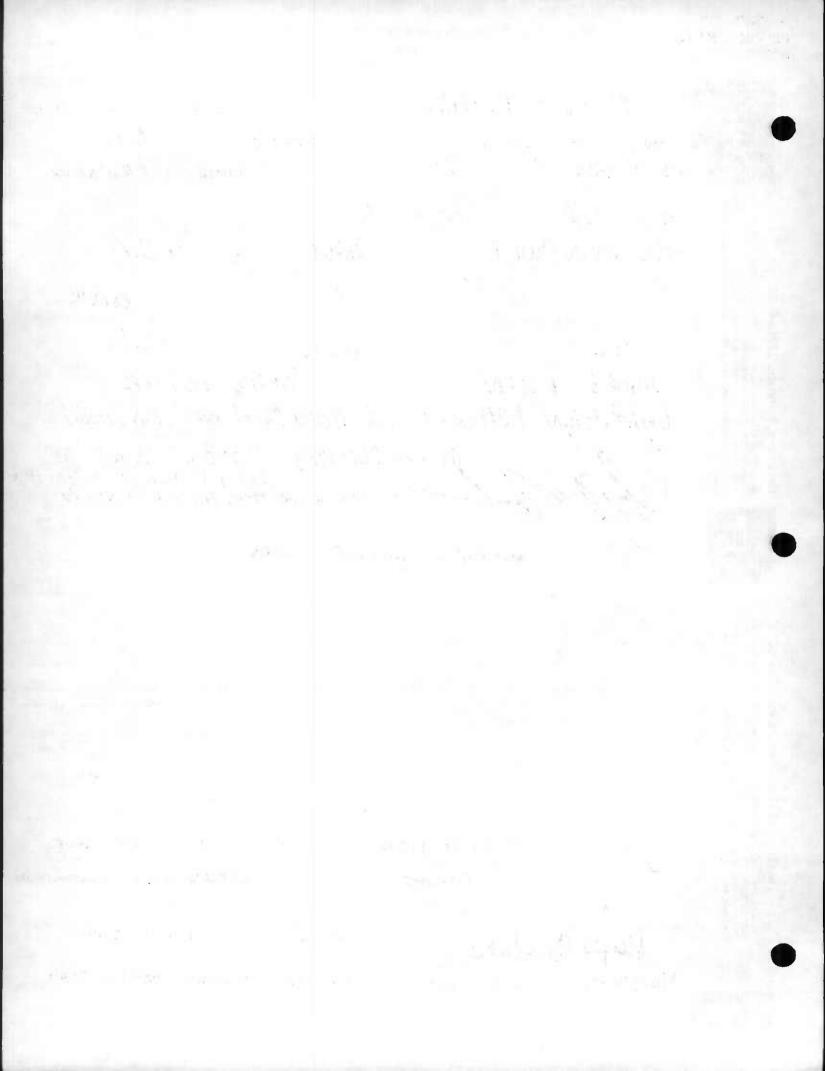


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 29 1998 AUGUST 1:30 A /Medical 4b. City, Town, or Location of Deeth 4e Fecility Name (If not institution, give street and number) 4c. County of Deat **Examiner** MARYLAND SHOCK TRAUMA BALTIMORE
If Under 24 Hrs Social Security Number 19-90-3286 6. Sex 7. Age (In xrs. last birthday) 9. Birthplece (State or Foreign **Funeral** 112 M 2□ F Min Months Days Hours Yrs Director Usual Residence of Decedent 10a State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Director Zip Code 10e et and Number 10g. Citizen of What Country? than "natural", or items 33s or the Medical Examiner must be 120 Funeral 12. Was Decedent Ever In U,S Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 ☐ Married 1 Yes 2 No
If Yes, Give
Year or Dates: 1□ Yes 2☑ No Specify: þ 3 □ Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupetion
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Mechanic College (1-4or 5+) ry (0-12) 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Name (First, Middle, Last) 86 Pages 1 and 2 should be next of Health and Mental 5 marked 19a. Aforment's Name/Relationship (7 R-AUNT Health I Baltimore, 20a. Method of Disposition Date 1 bit Burnal 2 Commetion 3 F 4 Donation 5 Other (Specify) m 5 Department of Important: If 240 FREDHILTON PASS complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, re. List only one cause on each line. **Physician** /Medical Immediate Cause (Finel CUMBLOS diseese or condition resulting in death) Examiner Examiner physician and the burial-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or as a consequence of): of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as e consequenca of) as esn signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No þ 24b. Were eutopsy findings available prior to Completed 24a. Wes en eutopsy performed? completion of cause of deeth? page 2 s 18 Yes 2 □ No certificate 1 Nes 2 No 25. Was case referred to medical examiner? Be 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 9 1 Yes 2□ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 【X DOA After this funeral 28d. Describe how injury occurred 27. Manner of Deeth 28b. Time of Injury 28e. Date of Injury (Month, Day Year) Certification: 28c. Injury at Work? or Attending F 1 Natural 5 Pending investigation 29 98 1 Yes 2 14No Surgerer was 1121 Hospitel or Attendi 124 hours affer death Funeral Director 2 Accident 3 Syficide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Dynomicide STROBT GOOBUK W. LON 4410WST BANMONETUN 1 Certifying Phyaicien: To the best of my knowledge, death occurred at the time, date and pleca, end due to the ceuse(s) end menner es stated.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date and place, and due to the ceuse(s) end menner stated. 29a. Certifier Medicai (Check only one) To the within 2
To the F 29d. Date signed (Month, Day, Year) AUGUST 29, 1998 29b. Signature end title of cartifie 29c. License number O.C.M.E we 30, Name end address of person who completed cause of death (Item 23e) (Type, Print) MARY MILTO D. Korore un. 111 Penn Street, Baltimore, Maryland 21201 31 Date filed (Month, Day, Year) \$2. Registrer's Signature State SEP 0 4 1998 Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 40 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month 3. Time of Death 34A-1 31, GLAODING HOUST 1998 am 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number) BALT MORE If Under 24 Hrs. 8. [BALTIMORE University of Maryland Medical System CITY If Under 1 Year 5. Social Security Number 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) Days Hours Months 10 M 2 XE 219-38-0766 JANUARY 8, 1940 Kentucky Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Talbot 1 ☐ Yes ▼☐ No Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 27859 Villa Road 21601 USA 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Yeer or Dates: 1 Never Married 2 Married 1 ☐ Yes No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Chester Butcher Ella Price 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Richard P. Gladding/husband 27859 Villa Road Easton, MD

Metro Crematory, Inc. 9/3/98 Baltimore, MD

ESPIRATORY DISTRESS SYNDROME

20c. Location - City or Town, Stete

August 31, 1998

Baltimore, MD

21228 Approximate Intervel Between Onset end Deeth

permit. Pages 1 and 2 should be filed within 72 hours effer c Depertment of Health and Mental Hygiene. Important: If item 27 Ia marked other than "natural", or item any Injury or other traumatic event, the Medical Evanmen

Physician

/Medical

Examiner

10e. State

MD

Director

Funeral

þ

Completed

Be

20e. Method of Disposition

Immediate Ceuse (Final

disease or condition resulting in deeth)

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

death with the Marylend

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

> physician, s the burial signed by the a certificate has b this

or Attanding Physician: funeral director. After efter death. 2 Hospital 24 hours To the Hosp within 24 hor To the Fune completely fi

Division of Vital Records, P.O. Box 68760,

Examiner MYELOMA MULTIPLE Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Lest Due to (or es e consequence of) Physician/Medical Due to (or as a consequence of) Pert II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Pert 1. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24e. Was en eutopsy performed? 24b. Were eutopsy findings eveileble prior to Completed completion of cause of deeth? 1 Yes 2 □ No 1 ☐ Yes 2 No Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 1 Npatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury et Work? Naturel 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred et the time, date end piece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, date end pieca, end due to the ceuse(s) and menner stated. edicai 29a. Certifie (Check only one) 29b. Signature and Ittle of 29c. License number 29d. Date signed (Month, Day, Year)

20b. Place of Disposition (Name of cametery, crematory or other place)

21. Signature of Fungal Servica Licanses

Dawn F Donald

22. Name end Address of Fecility

Cremation Society of Maryland, Inc.
299 Frederick Rd. Baltimore, MD 212

23a. Perl1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest,

Approximation Society of Maryland, Inc.
299 Frederick Rd. Baltimore, MD 212

Approximation Society of Maryland, Inc.
299 Frederick Rd. Baltimore, MD 212

Approximation Society of Maryland, Inc.
299 Frederick Rd. Baltimore, MD 212

Approximation Society of Maryland, Inc.
210 Frederick Rd. Baltimore, MD 212

Approximation Society of Maryland, Inc.
299 Frederick Rd. Baltimore, MD 212

Approximation Society of Maryland, Inc.
299 Frederick Rd. Baltimore, MD 212

Registrar

FADEYI 31. Dete filed (Month, Day, Year) 32. Registrar's Signature SEP 0 4 1998

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Wike



University of MD Medical Center

12393

Mary Branch of the same DAY S pageons

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Month ELIZABETH D. GERBER 08 5:34Pm 4a. Fecility Neme (If not institution, giva streat and number) 4b. City, Town, or Location of Death 4c. County of Death Havre De Grace Harford

| Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hour Harford Memorial Hospital 5. Social Sacurity Number Birthplace (Stete or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 215-32-4287 1□M 2⊠F Yrs. 64 Usual Residence of Decedant 10a Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits Baltimore 1 ☐ Yes 2 ☐ No Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1159 Foxwood LAne 21221 USA 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yes 2 ☑ No If Yes, Giva Yeer or Detes: 11. Marital Stetus 13. Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Married 2 Married 1 Tes 2√ No Specify: Specify: White 3X Widowed 4 ☐ Divorced 16e. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme) William Albert Blevins Lois HAzel French 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 1159 Foxwood Lane Baltimore Md. 21221 Lois A. Gerber /daughter 20b. Place of Disposition (Neme of cematary, crematory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Ramovel from Stata Gardens of Faith 9/2/98 Rossville Md. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name end Addrass of Facility Connelly Funeral Home of Essex onne 300 MAce AVe. Baltimore Md. 21221 29a. Pert1. Enter the disease, or complications that caused the death project enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only and cause on each line. Immediete Ceuse (Final disease or condition resulting in death) STRCKE HOUR Due to (or es e consequence of) Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of): Pert II. Other stgniffcant condittons contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dld tobacco usa contribute to the causa of death? HYPERFENSION 1 Yes 2 No 3 Probably 4 Unknown RHEUMATOID ARTHRITIS 24b. Were eutopsy findings 24e. Wes an autopsy available prior to completion of ceuse of deeth? performed? NONINGULINDEPENDENT DIABETES 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ R/Outpetient 3 ☐ DOA 1 ☐ Yes 2 No 27. Menner of Death 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 2 Accident 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Physician/Medical Examiner þ Completed Be

physician at s the buriel-t Attending P

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of Vital

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Physician

/Medical

Examiner

Funeral

Director

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Herns 23a

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Peges 1 end 2 should be filed within in of Health end Mentel Hygiene.

T: If Item 27 is merked other than "n y or other traumetic avant

Physician

/Medical

Examiner

and I-transit

21215-0020

Baltimore, Maryland

Director

Funeral

by

Completed

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Certification: To ector: 4 Homicide Medicai 29a, Certifier (Check only one)

6 Could not be

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

1 Certifying Physicfan: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner es steted.

2 Medical Examtner: On the basis of axamination and/or investigetion, in my opinion, death occurred et the time, date end place, end dua to the causa(s) end manner stated. 29b. Signature end title of certifiar

Indrew Nowalionsly up

29c. License number
29d. Date signed (Month, Dey, Year)

AV&UST 29, 1998

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

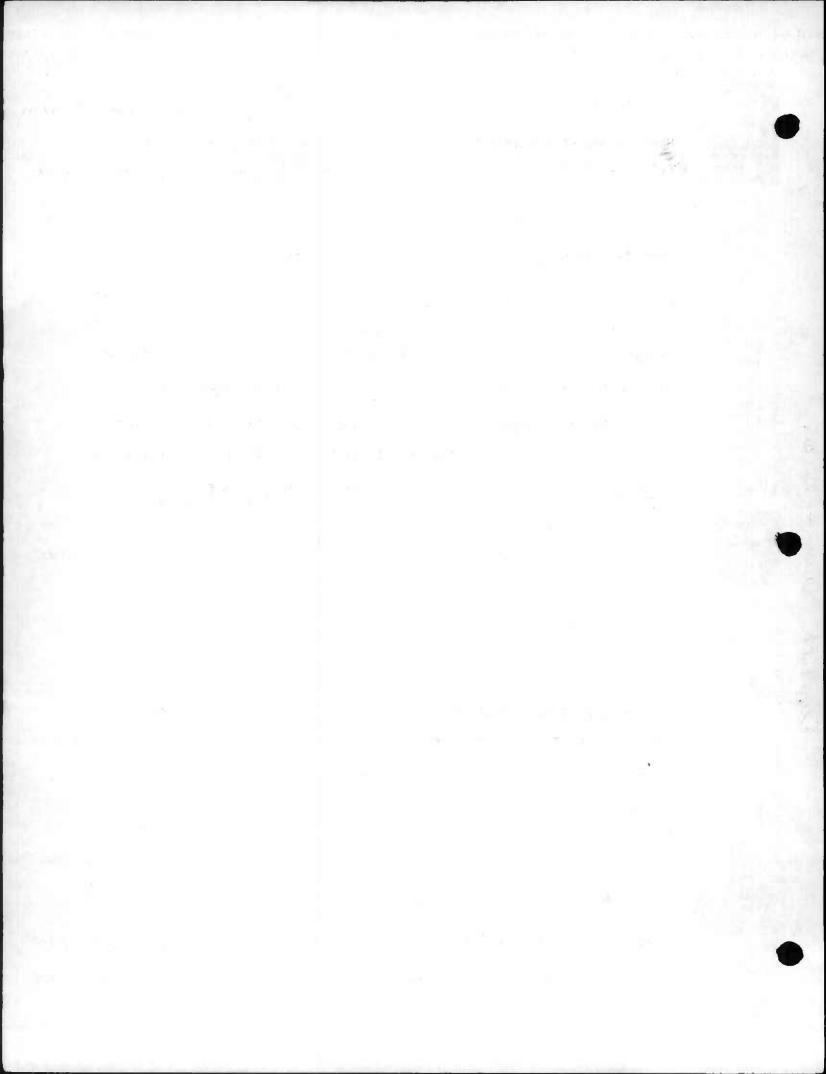
125 N, MAIN ST. BELAIR, MD 21014 ANDROW NOWAKOWSKI MD 31. Dete filed (Month, Day, Year)

State Registrar

SEP 0 4 1998



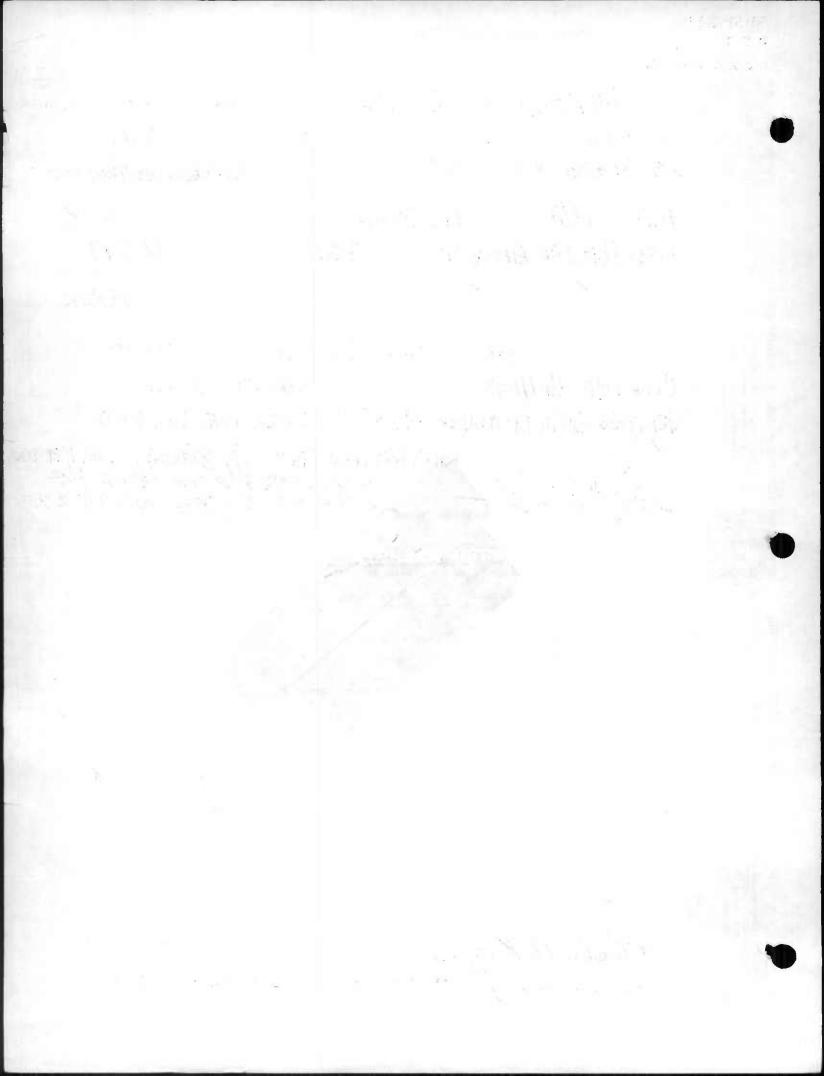
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

B.K.S HERBERT	"ĢI	State of Maryland / Departm LITAM PART 1, 27 28A-F PER MEO G763 9-11-98 WR. Certific	ent of Health and Mate of Death		iene 98	27142
Physic /Medi Exami	ian ical	1. Decedant's Name (First, Middle, Last) HERBERT 4a Facility Nama (If not institution, give streat and number) 1036 POPULAR GROVE STREET	4b. City, Town, or L BALTIMO	2. Data of Daati Month SEPT .	<u> </u>	3. Time of Death 12:00 PM
Funeral Director		5 Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) If U Mon Usual Rasidance of Dacedant	ndar 1 Yaar If Undar 24 Hrs.	8. Data of Birth	9. Birth Q3, 1943 MP	nplaca (Stata or Foraign
deeth with the Maryland me 23e or 28e-f show met be notified at	rector	10a. State 10b. County 10c. City, Town or Location BALTIMORE 10e. Street and Number 10f	Zip Coda , ,	10	0g. Citizen of What Co	10d. inside City Limits 1 No Yas 2 No untry?
5-0020 72 hours efter death with natural', or items 23a or pricel Examiner must be n	by Funeral Director	1 Navar Marriad 2 Married 1 Yas 2 No	QIQIO scedant of Hispanic Origin? (Specify Cuban, Maxican, Puarto s 207No Specify:	pacify Yas or No- Rican, atc.)	14. Race - Amar Black, White Specify: BL	
21215-0 ed within 72 ho ygjene. her then "natura it, the Medical	Completed	Elementary/Secondary (0-12) College (1-4or 5+) DRUG	work done during most of work Tusa ratired) SPECIALIST	king	Rehab	ndustry
should be fill marked oth	To Be	17. Father's Name (First, Middle, Last) CLARENCE GILIAM 19a, Informant's Name/Relationship (Type, Print) 19b.,Mailing Add	Verni	ia (First, Middle, N CC OU ral Routa Number,	iten	ip Coda)
other trau		Vernice Gilliam - Mother 4004 20a. Method of Disposition 20b. Place of Disposition	CARLISCE	AVE.	BALTO MI)
permit. Page Department of Important: it any Injury or once.		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Non 23a. Barn Euler (the disease, or complications that caused the death. Do not enter the	XIAL PARK 9	16/96k Tuntos On Pos or raspiratory arre	ANDAUSTURAL PALTI	VN, MARYLAN FIND 21229 Approximate Interval Batwaan
Physician /Medical Examiner	er	Immatiata Causa (Final disaasa or condition rasulting in daath) a. COCAINE INTOXI Dua to (or as a consequence				Onsat and Death
cords, F.O. box 66/60, requires that the death certificete be asscuted been signed by the attending physician and should be detached for use as the burial-transit	edicai Examiner	Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last b. Dua to (or as a consequence or consequence or consequence) c. Dua to (or as a consequence or consequence)		L		d .
that the death cert sed by the attending detached for use	y Physician/Med	d Part II. Other significant conditions contributing to death but not resulting in the underlying to death but not resulting in the underlying to death but not resulting in the underlying to death but not result	ng causa givan in Part I.			to the cause of death?
has has	Completed by			24a. Was an perform	nad?	Nere autopsy findings aveilabla prior to completion of causa of death?
= F # 8	Be Co	25. Was casa rafarrad to medical	26. Placa of Daa	th (Check only on		Yas 2 No
OI VICE Physician: this certific ral director,	2	examinar? 1/2 Yas 2 No Hospital: 1 inpatiant 2 ER/Outpatient 3 27. Mannar of Death 28a. Data of Injury 28b. Time of A			nce 6 Other (Spec	pify)
ding ding	Certification:	1 Natural 5 Panding (Month, Day Year) Injury 2 Accident investigation FOUND: 9-2-98 FOUND: 11:4		UNKNO		ral Routa Number,
plint of Attention of a start of		28e. Placa of injury - At homa, farm, streat, fa building, atc. (Specify) FOUND: HOME 29a. Certifier 1 Certifying Physictan: To the best of my knowladga, daath occur		BALTIMORE	CITY, MD. PO	PLAR GROVE ST.
To the Hose within 24 to To the Functional Completely	Medicai	(Check only one) Medical Examiner: On the basis of exeminetion end/or investige and mannar stetad. 29b. Signatura and titla of cartifiar		rred at tha time, de		to the ceuse(s)
C+	ate	30. Nama and addrass of person who completed causes leath (Itam 23a) (Type, Print) THE WISHER (Month, Day, Year) 32 Registrar's Signatura	reet, Baltimon	re, Maryl	and 21201	

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month 4:35 PM Eula Hortor 08 30 /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Homewood Futurecare BALTIMORE if Under 24 Hrs. Hours Min. N/A If Under 1 Year 5. Sociel Security Number 8 Sev 7. Age (In yrs. last birthday) Birthpiace (State or Foreign Country) 10 M 20 F **Funeral** Deys Yrs. Director 260-09-3515 7/24/04 SOUTH CAROLINA Usual Residence of Decedent filed within 72 hours after death with tha Maryland Hygiana. 10e State 10h County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show 1 ☑ Yes 2 ☐ No Director N/A MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1932 RIGGS AVENUE 21217 Funeral U.S. 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American indian, Bleck, White, etc. 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify. þ 3 ₩ Widowed 4 Divorced BLACK Completed 7 is marked other than "nature traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) -0housekeeping domestic 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) . Pages 1 and 2 should be fin mant of Haalth and Mental Hy ant: If item 27 is marked oth jury or other traumatic event Be RICHARD HEARST CARRIE PRESTLEY 2 19e. Informent's Neme/Relationship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 4014 FERNHILL AVENUE-BALTIMORE, MARYLAND JUANITA M. RUSSELL (EXECUTOR) 21215 20b. Pieca of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete permit. Pages Department of Important: If It any Injury or o N Buriai 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 9/5/98 BALTIMORE, MARYLAND KING MEMORIAL PARK 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility ELIZABETH L. PHILLIPS, P.A. 1721-27 N. MONROE STREET-BALTIMORE, MD 21217 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximate Interval Batween Onset and Death **Physician** /Medicai immediate Cause (Final disease or condition resulting in deeth) Examiner Examiner physician and the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Last tract Due to (or es e consequenca of) usa P Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 1 No 3 Probably 4 Unknown

Physician/Medical signed by the a d be deteched f ģ plnods Completed hes paga 2

Be

2

Certification:

edical

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. cartificate or Attanding Physician: director. this funaral Aftar after deeth. filled in by 24 hours a Hospital complataly To the P within 2 To the F

dult marasmus pronu renal 26. Place of Deeth (Check only one)

25. Was case referred to medical exeminer? Hospitel: 1 ☐ inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Menger of Deeth 28c. Injury at Work? 28a. Dete of Injury (Month, Day Year) 28b. Time of 1 Naturel

5 Pending investigation 6 Could not be

28e. Place of injury - At home, ferm, street, fectory, office building, etc. (Specify)

11 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and manner as stated. 2 Medical Examinar: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, dete end placa, and due to the cause(s) and menner stated.

2700 N. Charles St. Balto, Md 21218

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

24e. Wes en eutopsy performed?

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

1 Yes 2 No

28d. Describe how injury occurred

29b. Signeture, end title of certifier soston 29c. License number 28462

1 Yes 2 No

29d. Date signed (Month, Dey, Year)

24b. Were autopsy findings available prior to completion of cause of death?

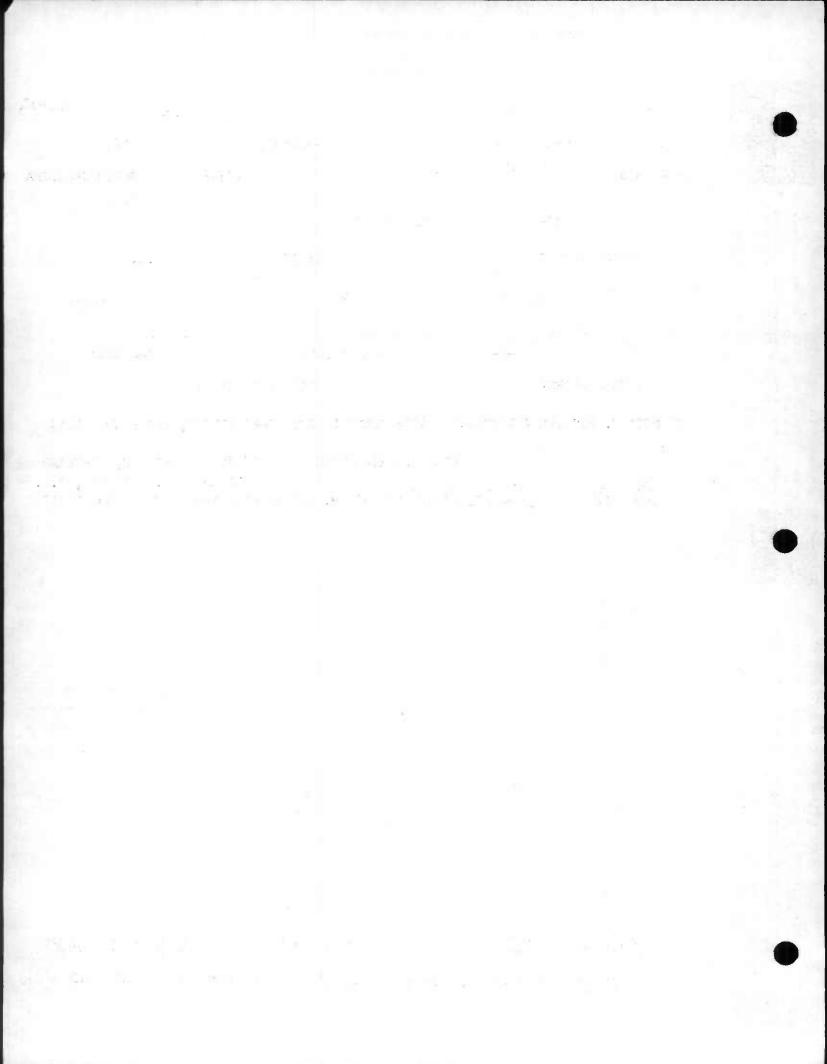
1 ☐ Yes 2 ☐ No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Futurecare Homewood Boston

32. Registrar's Signature 31. Date filed (Month, Day, Year) **SEP 04**

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item#4c per Phy G763 9/4/98 EW 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death HARTLOVE ETHEL 500 PM AUGUST 1998 22 4a. Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE CHURCH Home AND HOSPITAL If Undar 1 Yaar If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) 213 16 6382 1 M 2 F 90 Sept. 3, 1907 Pennsylvania Usual Rasidance of Dacedant 10b. County 10c. City, Town or Location 10d. Insida City Limits **Baltimore** Dunda1k 1 Yas 2 No 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 1756 Melbourne Road 21222 U.S.A. 12. Was Decedant Evar In U,S. Armed Forcas? 14. Race - Amaricen Indian, Black, Whita, atc. Was Decedant of Hispanic Origin? (Specity Yas or No-If Yas, specify Cuban, Maxican, Puarto Ricen, atc.) 1 Nevar Married 2 Married 1 ☐ Yas 2 ☐No If Yas, Giva Yaar or Datas: Specify: White 1 ☐ Yas X No Specify: 3 Widowed 4 □ Divorced 16a. Decedant's Usuai Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Buainass/Industry Elamantery/Secondery (0-12) College (1-4or 5+) 6th Homemaker Own Home 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) Peter Loomis Despina Theodosiou 19a. fnformant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Irene Long / Daughter 1756 Melbourne Rd., Dundalk, Md. 21222 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cramation 3 □ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) OakLawn Cemetery 8-26-98 Baltimore, Md. 21. Signature of Funaral Sarvice Licensaa 22. Nama and Addrass of Facility Bradley-Ashton-Dabrowski-Matthews Funeral Home, Inc athews 2134 Willow Spring Rd., Balto., Md. 21222 23a. Part1. Entar tha disaasa, or complications that caused tha daath. Do not antar tha mode of dying, such as cardiac or respiratory arrest, shock, or haart feilure. List only one cause on each line. Approximata Intarval Batween Onset and Death Immediata Causa (Final disaaaa or condition rasulting in death) IMMEDIATE. MYOCARDIAL INFARCTION Dua to (or as a consequence of): YCARS COLON CARCINOMA Sequentially list conditions, If any, leading to immadiata cause. Entar Underlying Cause (Disaase or injury that initiated avants rasulting in death) Last Dua to (or as a consequance of): INKNOWN HYPERTENSION Dua to (or as a consaquance of): Part ff. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 No 3 | Probably 4 | Unknown 24a. Was an autopsy performed? 24b. Wara autopsy findings available prior to complation of causa of daath? 1 Yas 2FTNO 1 Yaa 2 No

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. Stata

Md.

Funeral

Director

r 28a-f show

Director

Funeral

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Completed

2

the Maryland

filed within 72 hours after death with ir than "natural", or items 23s or the Medical Examiner must be r

Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If Item 27 is marked other than Inty or other traumatic event, the M

permit. Page Depertment of Important: If any injury or

Baltimore, Maryland 21215-0020

Examiner Physician/Medical þ

Ded signed by 1 pege 2 director, this funeral death. or Attendation of the order An 24 house.
The Funeral Direction of filled in by the

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Division of Vital Records,

Completed Be 2 Certification:

Hospital To the Hosp within 24 ho To the Fune completely f

30. Name end address of person who complated ceusa of death (Itam 23a) (Type, Print) A, SY MD

29e. Certifian

31. Data filad (Month, Day, Year) State Registrar

edical

SEP 04 1998

25. Was cesa referred to medicel axaminer?

29b. Signatura and titla of certifiar

1 Yas 2 No

27. Mannar of Deeth

1 ANatural

3 ☐ Suicida

2 ☐ Accident

4 Homicida

(Check only one)

5 Panding Invastigation

6 Could not be

Hospital:

CHURCH HOME AND

1 Inpatiant

28a. Deta of Injury (Month, Day Year)

HOSPITAL 32. Registrar's Signatura

2 ER/Outpatient 3 DOA

28b. Time of

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28c. Injury et Work?

1 ☐ Yas 2 ☐ No

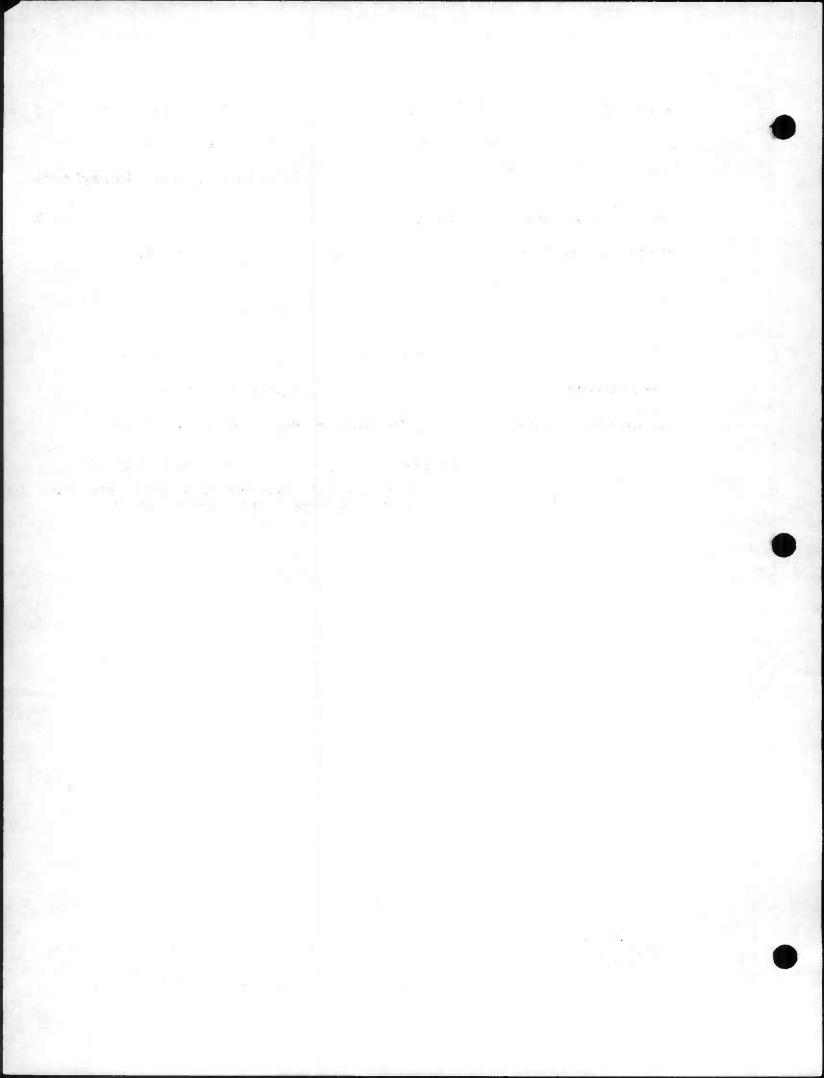
1 Certifying Physician: To the bast of my knowledga, daath occurred et the tima, deta and piace, and dua to tha causa(s) and manner as stated. 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29c. Licansa number 29d. Data signed (Month, Day, Year) D39629 AUGUST 22 1998 MD 21231 BALTIMORE

28d. Dascribe how Injury occurred

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

28. Placa of Death (Check only ona)

Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

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uneral		5. Sociel Sacurity Nu		6. Sex			st birthdey)	If Undar 1 Yo Months Da		24 Hrs. Min.	8. Date of Bir (Month, De	th v. Year)	9. Birthp	laca (Stata or	Foreign
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214-	d) (b)		-													
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DHMH 16 Ray 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) **Physician** 9:30 AM ENNINGS /Medical 4b. City, Town, or Location of 4a Facility Neme (If not institution, give street end number, Examiner HOSPITAL AGNES Buttimore If Under 24 Hrs. 8. Date of If Under 1 Year 8. Date of Birth (Month, Dey, Year) 6 Sex 7. Age (In yrs. last birthdey) 9. Birthplece (State or Foreign 5. Sociel Security Number **Funeral** 12 M 2□ F Months Deys Hours Min Yrs. 79 APRIL 24,1919 MARYLAND Director 212-09-0690 Usuel Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at MARYLAND N/A BALTIMORE N☐ Yes 2 ☐ No Directo 10e. Street end Number 10f, Zip Code 10g. Citizan of Whet Country? 21223 1010 PARKSLEY AVENUE U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ②No if Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ No Specify: Specify. WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 18a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elamantary/Secondary (0-12) Collage (1-4or 5+) POST OFFICE 9TH GRADE LETTER CARRIER 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumame) THOMAS JENNINGS FLORENCE OUINN 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) 1010 PARKSLEY AVENUE - BALTIMORE, MARYLAND 21223 MARJORIE JENNINGS (WIFE) 20b. Piece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removal from State 9/3/98 BALTIMORE 4 Demaijon 5 Wither (Specify) ENTOMBMENTLOUDON PARK CEMETERY Injury Funeral Service Licens 22. Name end Address of Fecility any HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE-BALTIMORE, MARYLAND 21229 23a. Pert1. Enter the disaese, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one cause on each line. Approximate Interval Batween Onset and Deeth Physician Immediate Cause (Final disease or condition rasulting in daath) Bilateral Bronchogenic Carcinoma 2 months /Medical Examiner Examiner Sequentially list conditions, if eny, leading to Immediate ceusa. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Physician/Medical Due to (or as e consequance of) 98 Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yae 2 No 3 Probably 4 Unknown Atrial fibrillation by 24a. Wes en eutopsy performed? Pericardial effusion 24b. Wera autopsy findings eveilable prior to Completed completion of cause of deeth? Pleural effusion 1 ☐ Yes 2 No 25. Wes cese referred to medical exeminer? 26. Pleca of Deeth (Check only one) Certification: To Be Hospitel: 1 Impatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residance 6 ☐ Other (Specify) 28d. Dascribe how injury occurred 27, Mannar of Death 28c. Injury at Work? 1 Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be datermined 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physicien: To the best of my knowledge, deeth occurred at tha tima, data end plece, end due to tha causa(s) end menner es stated. Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, death occurred at the time, data and plece, end due to the cause(s) end menner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ocucoria OID.

S. Tancovici, ST. AGNES HOSP., 900 Caton Ave, Balto, MD, 21229

State Registra

31. Date filed (Month, Dey, Year)

30. Name end address of person who completed cause of deeth (Itam 23e) (Type, Print)

SEP 0 4 1998

32. Registrer's Signature

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page 2 should

certificate

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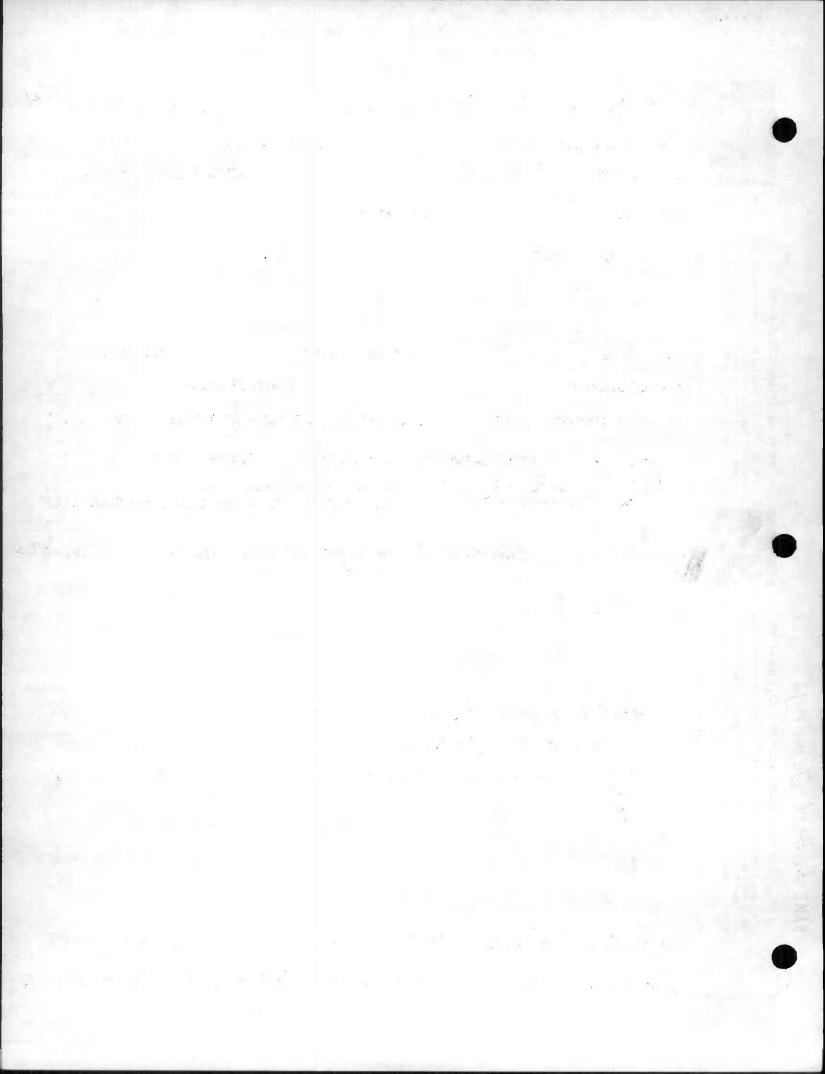
Director

To the Hospital within 24 hours of To the Funeral I completely filled

Tennings

AME Kobert

altimore, Maryland 21215-0020



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month 16, 1998 Elmer L. Jainniney August 23:06 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Washington Hagerstown If Undar 24 Hrs. Hours Min. 7. Aga (In yrs. last birthday) If Under 1 Year 9. Birthplace (Stata or Foreign Country) West Virginia 5. Social Sacurity Number Months Days 1⊠M 2□ F 78 236-24-4655 Yrs. Usual Rasidanca of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits WV Berkeley Martinsburg Vas 2□No 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 615 Albert Street 25401 USA 12. Was Dacedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, White, atc. 1 Navar Marriad 2K Marriad 1 ☐ Yas 2 ☐ No If Ŷas, Giva Yaar or Datas: 1 ☐ Yas 2 X No Specify: white 3 ☐ Widowad 4 ☐ Divorced Specify: 15. Dacedant's Education (Spacify only highast grada complated) 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) 7 th maintainence auto plant 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maldan Sumama) Clyde Jainniney Maude Morgan 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Florence Jainniney - wife 615 Albert Street Martinsburg, WV 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Rosedale Cemetery 8/19/98 Martinsburg, WV 21. Signatura of Funaral Sarvice Lonsee 22. Nama and Addrass of Facility Rosedale Funeral Chapel, Inc. 2060 Rosedale Rd., Martinsburg, WV Port. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, hock, or heart failure. List only one cause on each line. Canloves 25401 Approximata Intarval Batween Onsat and Daath Immadiata Causa (Final disaasa or condition rasulting in daath) Massine 8.4.98.-8.169 7 Dua to (or as a consequence of) 7 Dua to (or as a consequanca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Maso oml 24b. Wara autopsy findings availabla prior to complation of causa of daath? 24a. Was an autopsy performed? 2 100 1 Yas 1 ☐ Yas 2 ☐ No 26. Placa of Daath (Check only ona)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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Неття 23а death

Pegas 1 and 2 should be filed within 72 hours eftar on ant of Health and Mental Hygiena. Int: If Item 27 Is marked other than "natural", or item

permit. Pegas 1 end 2: Department of Health er Important: If Item 27 is any injury or other trau

Baltimore, Maryland 21215-0020

P.O. Box 68760,

Records,

Division of Vital or Attending Physician:

The law requires that the death certificate

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After

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To the Hosp within 24 hor To the Fune complataly fi

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the Maryland

Physician/Medical Examiner Sequantially list conditions, if any, laading to Immadiata causa. Enter Undarlying Cause (Disaasa or Injury the that initiated evants rasulting in daath) Last 88 signed by the a

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Certification: To

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27.	Mannar of	Daath			

Hospital: Inpatiant 2☐ ER/Outpatiant 28a. Data of Injury (Month, Day Year) 5 Panding invastigation

28b. Tima of Injury

28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Spacify)

Injury at Work? 1 ☐ Yas 2 ☐ No

3□ DOA

Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 28d. Dascribe how injury occurred

Location (Street and Number or Rural Routa Number, City or Town, Stata)

21713

29a. Cartifiar (Check only one)

1 Natural

2 Accidant

3 Suicida

4 Homicida

Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signatura and titla of cartifian

29c. Licansa number

29d. Data signed (Month, Day, Year)

6 Could not be datarminad

30. Nama and addrass of person who complated causa of daath (Itam 23a) (Typa, Print)

G. Qadir, MD 31. Data filad (Month, Day, Yaar) 20311 Lapans Road, Boonsboro, MD 32. Registrar's Signatura Taneva



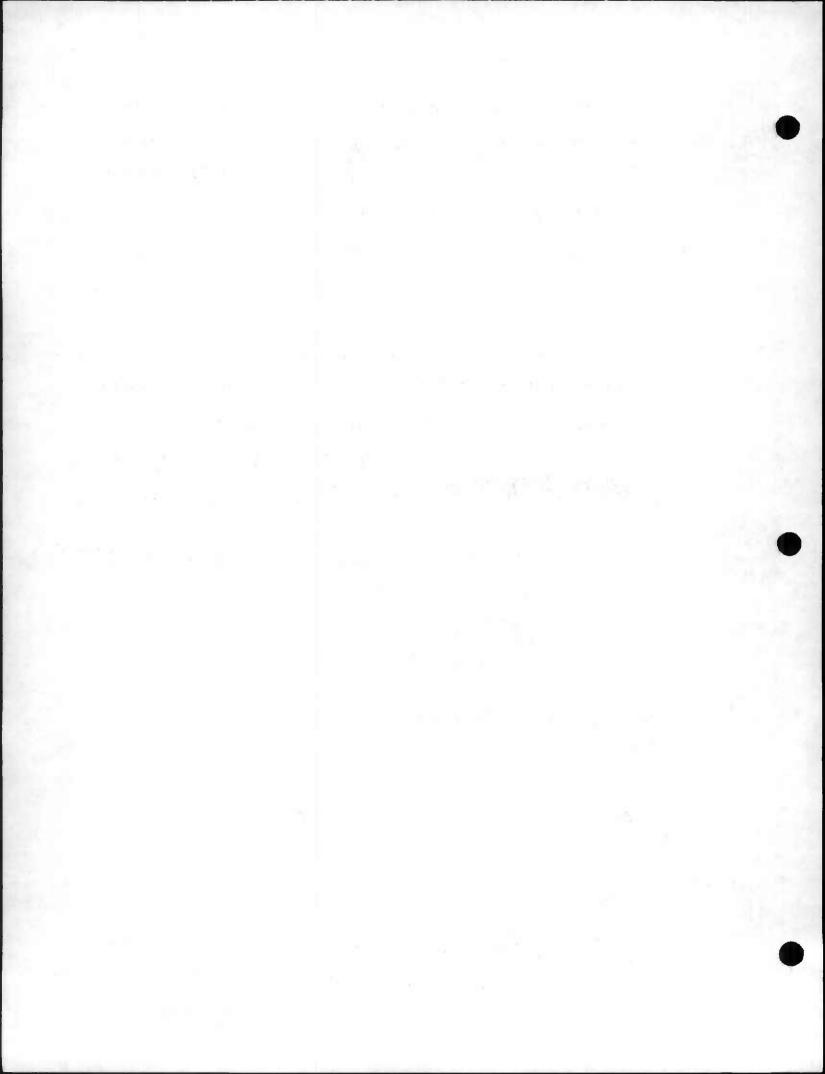
State Registrar



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State of Maryland / Department of Health and Mental Hygiene

Physician Astronomy Astr						,	Certif	icate of	Death		Reg. No. 9	3 2	7148
Examiner Fundral Green Nursing and Rehab. Center Eulicitic tity Fundral Green Nursing and Rehab. Center Fundral Fundral Green Nursing and Rehab. Center Fundral Green Nursing and Rehab. Center Fundral Green Nursing and Rehab. Center Fundral Fundral Green Nursing and Rehab. Center Fundral Green Nursing and Rehab. Center Fundral Fundral Green Nursing and Rehab. Center Fundral F		Dhualai		1. Decedent's Name (First, Middle, Les)							Veer	3. Time of Deeth
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Physician /Medical Examiner

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7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after tent of Health and Mental Hygiene.
nt: if item 27 is marked other than "natural", or ite

Baltimore, Maryland 21215-0020

Division of Vital Records. P.O. Box 68760.

Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest Physician/Medical

Pert II.	Other significant conditions of	ontributing to death	but not resulti	ng in the underlying	cause given in Pert

1 ☐ Yes 2 ☐ No

25. Was case referred to medical exeminer? 1 Yes 2 No

6 Could not be determined

26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred

27. Manner of Deeth 1 Naturei 2 Accident 3 Suicide

4 Homicide

28e. Dete of injury (Month, Dey Year) 5 Pending investigation

28h Time of 28c. injury et Work? 1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

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1 Yes 2 No

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pieca, end due to the ceuse(s) end menner es steted. 2 Medical Examinar: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated.

29b. Signeture end title of certifier

M.D.

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

29c. License number

29d. Date signed (Month, Dey, Year) Sept

Registrar

30. Name and address of person who completed cause of deeth (item 23e) (Type, Print)

M. A.I. I. A.I. S. H. A. H. S. H. A. H. Care 31. Dete filed (Month, Day, Year) SEP 0 4 1998 32 Registrer's Signature

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 98 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Tima of Death AUGUST 2771 1998 10.00 AM Earl Phillip Kane 4b. City, Town, or Location of Death 4c. County of Death 4a Façility Neme (If not institution, give street end number) AKUNDEL HRUUDEL ORTH If Undar 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. lest birthday) 6. Sex Birlhplace (State or Foreign Country) Days Min 10 M 20 F Months Hours Yrs. July 23 1924 230 14 9904 74 Richmond VA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits Maryland Anne Arundel Hanover 1 ☐ Yes 25 No 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 147 Ridge Chapel Road 21076 United States 12. Was Decedent Evar In U.S. Armed Forces? boxYes 2 □ No if Yes, Give Yaar or Datas: 14. Race - American Indian, Black, White, etc. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 ☐ Yas 2 No 43-46 Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedant's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Heavy Duty Equipment Elementery/Secondary (0-12) College (1-4or 5+) 12 Fork Lift Mechanic 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meidan Sumeme) Samuel E. Kane Rachel Woodward 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) Wife 147 Ridge Chapel Road Hanover Maryland 21076 Flora A. Kane 20e. Method of Disposition ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 20b. Place of Disposition (Name of cametery, crametory or other place) Aug. 29, Daft 998 20c. Location - City or Town, State Lakemont Memorial Gardens Davidsonville Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Nama and Addrass of Facility Robert E. Evans Funeral Home, Inc. 20715 23a. Part1. Enter the disease, or complications that couled the death. Do not enter the mode of dying, such as cerdiac or raspiratory arrest, Approximately 16000 Annapolis Rd. Bowie Maryland 20715 Approximately 16000 Annapolis Rd. Bowie Maryland 20715 Approximately 16000 Annapolis Rd. Bowie Maryland 20715 Approximately 16000 Annapolis Rd. Bowie Maryland 20715 Approximately 16000 Annapolis Rd. Bowie Maryland 20715 Approximately 16000 Annapolis Rd. Bowie Maryland 20715 Approximately 16000 Annapolis Rd. Bowie Maryland 20715 Approximete intarval Between Onset and Death immediate Ceuse (Final CHRONIC OBSTRUCTIVE PYLMONARY DISEAS E 44EHRS disaase or condition resulting in death) Due to (or as e consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) Dua to (or as a consequence of) 23b. Did tobacco use contributs to the cause of death? Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Wera autopsy findings eveilable prior to completion of ceusa of death? 24a. Was an eutopsy 1 TYPS 2 PONO 1 Yas 2 No 28. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Dascribe how injury occurred 28b. Time of

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29a. Certifier

(Check only one)

Examiner

Division of Vital Records, P.O. Box 68760, of or Attending effer death.

25. Was cese referred to medical exeminer? 1 Yes 2 No 27. Manner of Death

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6 ☐ Could not be

28e. Date of injury (Month, Day Yeer)

28e. Place of Injury - At home, farm, straet, factory, office building, etc. (Specify)

28c. injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

1 🗹 Certifying Physician: To tha best of my knowledga, daath occurred at the tima, data and place, and dua to tha ceusa(s) and mannar as stated. 2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and piece, end due to the cause(s) and menner stated. 29d. Date signed (Month, Day, Year) 29c. Licensa number

HOSPITAL

29b. Signature and this of certifier

MEDICAL DOCTOR

D0052277

AUGUST 27TH 1998

MARYLAND

30. Name and eddress of person who completed cause of deeth (Itam 23a) (Type, Print) FRANCIS

KWASHIE 31. Date filed (Month, Dey, Year) SEP 0 4 1998

ATTIOUSE 32. Registrer's Signature

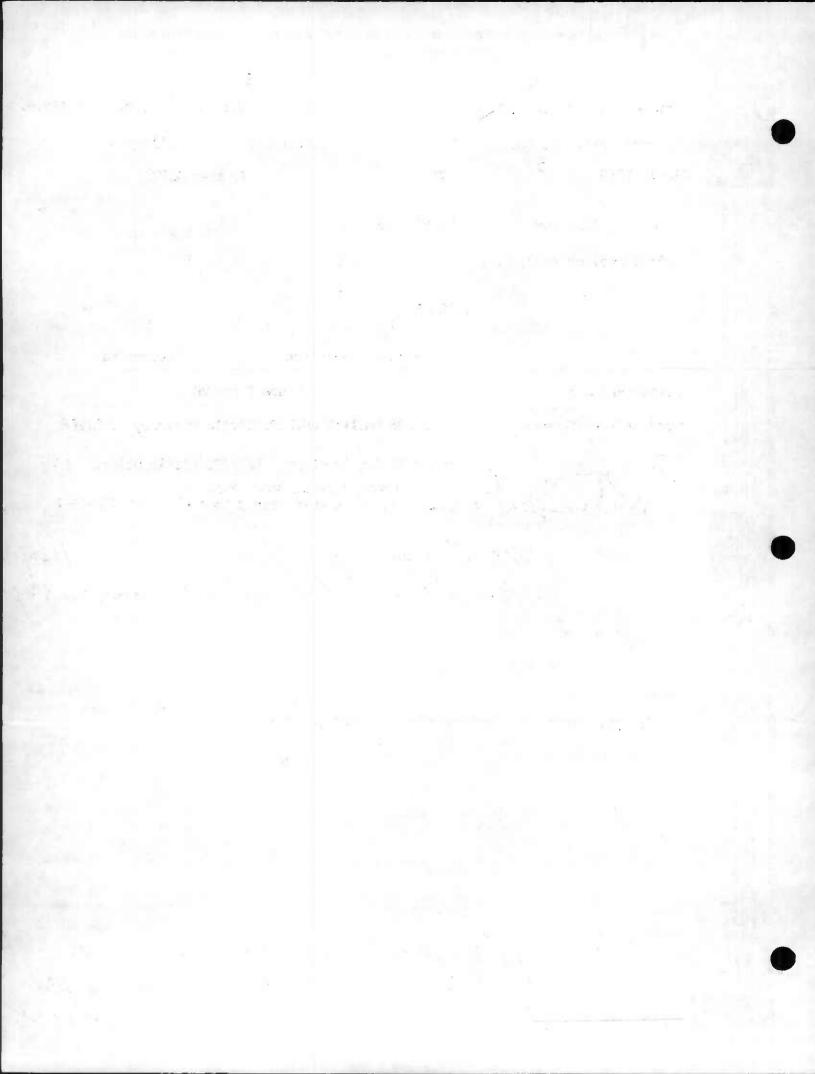
NORTH ARUNDEL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Item#31 per DVR G763 9/4/98 EW 2. Dete of Deeth 3. Time of Death 1. Decedent's Nema (First, Middle, Last) Month **Physician** 2145P.M. 1998 AUGUST 21 Philip L. Kolpack, Sr. /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street and number) 4c. County of Deeth Examiner Sacred Heart Hospital Cumberland Allegany 6. Sex 1 **X**M 2□ F 5. Social Security Number If Undar 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Months Days Yrs. 218-12-2395 Director November 22,1923 MD Usuel Residence of Decadent Pages 1 and 2 should be filed within 72 hours aftar death with the Marylend nent of Health end Mental Hygiena. The firem 27 is marked other than "natural", or items 23a or 28a-f show 10e Stete 10h County 10c. City. Town or Location 10d. Inside City Limits "natural", or items 23s or 28s-f show 1 ☐ Yes 2 No Director MD **Allegany** Little Orleans 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 32306 Mudlick Road, N.E. Funeral 21766 USA Wes Decedent Ever in U,S. Armed Forces?

1 XYes 2 No If Yes, Giva Yeer or Dates: 1943-45 Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. Black, White, etc. 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced White Completed th end Mental Hygiena.
7 Is marked other than "natur traumatic event, the Moderal 16e. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grade completed) Coilege (1-4or 5+) Elementery/Secondary (0-12) Repair Specialist Automotive 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be Herman Kolpack Grace Pierpont 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr Hazel Kolpack/Spouse 32306 Mudlick Rd.N.E. Little Orleans, MD 21766 20e. Method of Disposition 20b. Place of Disposition (Nama of cametery, crematory or other placa) 20c. Location - City or Town, Steta 1X Buriei 2 ☐ Cramation 3 ☐ Ramoval from Steta 4 ☐ Donation 5 ☐ Other (Specify) Piney Plains Cemetery 8/25/98 Little Orleans, MD 21/Signature of Furnifei Service 22. Name and Addrass of Fa Grove Funeral Home, P.A. 141 West Main Street Hancock, MD 21750-0368 23a. Pert1. Enter the disease, or complications their caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest shock, or heart failure. List only one cause on each line. Approximate Interval Between **Physician** /Medical Immediate Ceuse (Fine) diseese or condition resulting in deeth) Examiner Examiner Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Last Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as a consequence of) signed by the e 23b. Did tobecco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I 3 Probably 4 Unknown 1 Yes þ The law requires 24b. Were eutopsy findings available prior to completion of causa of deeth? 24e. Wes en eutopsy performed? Completed After this certificate has funeral director, page 2 2 DAO 1 ☐ Yes 2 ☐ No 1 Yes I or Attending Physician: after death. Director: After this certifica 25. Wes case referred to medical examiner? Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA Certification: To 27. Menner of Deeth 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Naturei 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident rector: 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 4 | Homicide A 24 hour. the Funeral Directory Hospital Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and pleca, end due to the cause(s) end menner es steted. To the Funer 29a. Certifier Medical 2 | Medical Examiner: On the besis of examinetion end/or Investigation, in my opinion, deeth occurred at the time, dete end place, end due to the ceuse(s) end menner stated. To the I 29d. Date signed (Month, Day, Year) 29c. License number 24, AUGUST 31. Dw 32. Registrar's State 1998

SEP 0 4

Registrar **DHMH 16 Rev 6/95**



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Dey Month 6:45 PM A. KIDWELL PATRICIA 1298 AUGUST 25 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) BALTIMORE If Under 24 Hrs. 8 Date of Birth Hours Min. (Month, Dey, Yeer) 4/19/19/42 9. Birthplace (Stete or Foreign Country) W.V. Months Days 1 M 2 F 56 235-68-0223 Usuel Residence of Deceden 10c. City, Town or Location 10b County 10d. Inside City Limits 1 Yes & No Berkeley Bunker Hill 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? Rt 2 Box 144 A 25413 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) nurse health care 12th 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Elmer L. Shade Lillian Sims 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) James H. Kidwell Rt 2 Box 144 A Bunker Hill, WV 20b. Placa of Disposition (Name of cametery, crematory or other place) Pleasant View Memory 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/29/1998 Martinsburg, WV 25401 Gardens 22. Name end Address of Fecility Rosedale Funeral Chapel, Inc. 21 Signature of Funeral Service Lines 2060 Rosedale Rd., Martinsburg, WV Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Deeth Immediate Ceuse (Final MULTIONAAN FAILURE disease or condition resulting in death) Due to (or es a consequence of): SEPSIS Due to (or as e consequence of): Due to (or as e consequenca of):

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29b. Signature and title of certifier

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The marked other than "natural", or frema 23a or 28a-f show fraumatic event, the Medical Examination must be notified at

L Pages 1 and 2 should be filed within 72 hours after timent of Health and Mental Hygiene.

Lant: If Item 27 is marked other than "natural", or ite

Baltimore, Maryland 21215-0020

Records, P.O. Box 68760

Division of Vital

the Maryland

Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Physician/Medical the

Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings eveilable prior to completion of cause of deeth? 24e. Was en autopsy 1 ☐ Yes 2 KNo 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28c. fnjury el Work? 28a. Date of Injury (Month, Dev Year) 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete and piece, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end piece, and due to the cause(s) end manner stated. 29e. Certifier

i or Attending Physician: aftar death. Director: After this certifica To the Hospital of within 24 hours a To the Funeral D

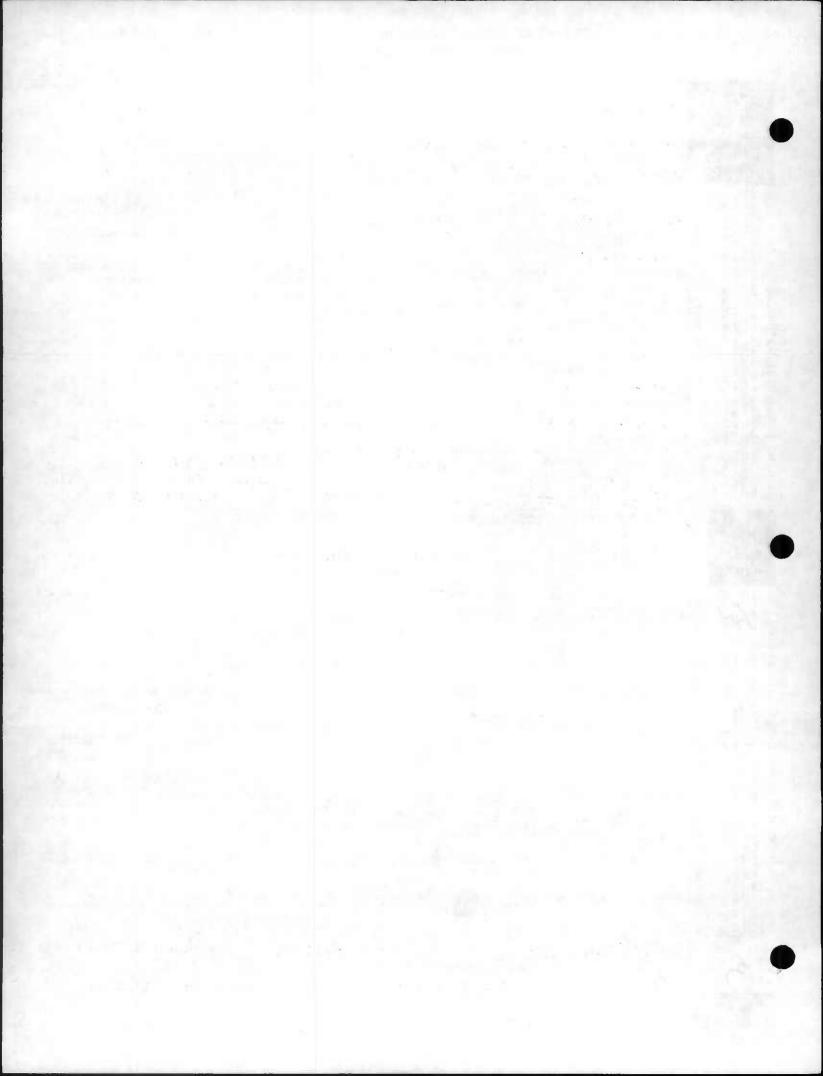
Registrar

29d. Dete signed (Month, Dey, Year) 29c. License number PIIZIY ALGUST 25, 1998

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) CHRISTINA

1998

ST BALTIMONE MID 21201 22 GREENE 32. Registraris Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (1) Amend: #10e,f,19b Per Informant Film G764 10-7-98RC Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth 2^{Dey} Month **Physician** Alice Mary McNamara Aug. 1998 2:52 PM /Medical 4e Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Atlantic General Hospital Berlin Worchester If Under 1 Year 8. Date of Birth (Month, Day, Year) MAY 19, 1910 If Under 24 Hrs. 5. Sociei Security Number 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) **Funeral** Months Deys Hours 1□ M 2□ F 215-01-6141 88 Maryland Director Usual Residence of Decedent the Meryland 10b. County 10c. City, Town or Location 10d. inside City Limits wode r 28a-f show 1 Ves 2 □ No Director Md. N/A Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? with r than "natural", or items 23s or the Medical Examiner must be 4428 Cedar Garden Rd. 208 S. BRUCE 21223 21229 USA Funeral deeth 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Bleck, White, etc. filed within 72 hours after 1 Never Married 2 Merried 1 Yes 2 No Specify: Maryland 21215-0020 Specify white If Yes, Give Year or Dates: À 3 ☑ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry al Hygiena. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home . Pages 1 and 2 should be filed w ment of Health and Mental Hygie lant: If item 27 is marked other ti jury or other traumatic event, to 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Hamilton Fogel Isabelle Hatfield 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)
4428 Cedar Garden Rd., Barto., Md. 21229 19e. Informent's Neme/Reletionship (Type, Print) George Goetz - son Baltimore, 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 8/31/98 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State permit. Paga Department of Important: if any injury or Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) Western Cemetery 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Gary L. Kaufman Funeral Home @ Meadowrige MP, Inc 7250 Washington Blvd., Elkridge, Md.

Part Former the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, a hock, or heart fellure. List only one cause on each line. 21075 Approximete Intervel Between Onset and Death **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in death) Examiner Examiner physician and s the bunal-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): certificata be execu Physician/Medical Due to (or es a consequence of): 80 950 for 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. the 1 Yes 2 No 3 Probably 4 Unknown signed by Division of Vital Records, þ 8 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed certificate has 1 ☐ Yes 2 No 25. Was case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Lo 2 ER/Outpatient 3 DOA 1 Inpatient this funeral 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) Sh Time of 28d. Describe how Injury occurred 28c. Injury et Work? Certification: 5 Pending Investigation 1 Tyes 2 No death. 2 Accident or Attendation of Attacher 6 Could not be determined 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 4 Homicide Hospital of 24 hours a Funeral D Cartifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

| Medical Examiner: On the best of examination and/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end manner stated. edicai 29a. Certifier To the Hosp within 24 ho To the Fune completely fi (Check only one)

29c. License number

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29d. Date signed (Month, Day, Year)

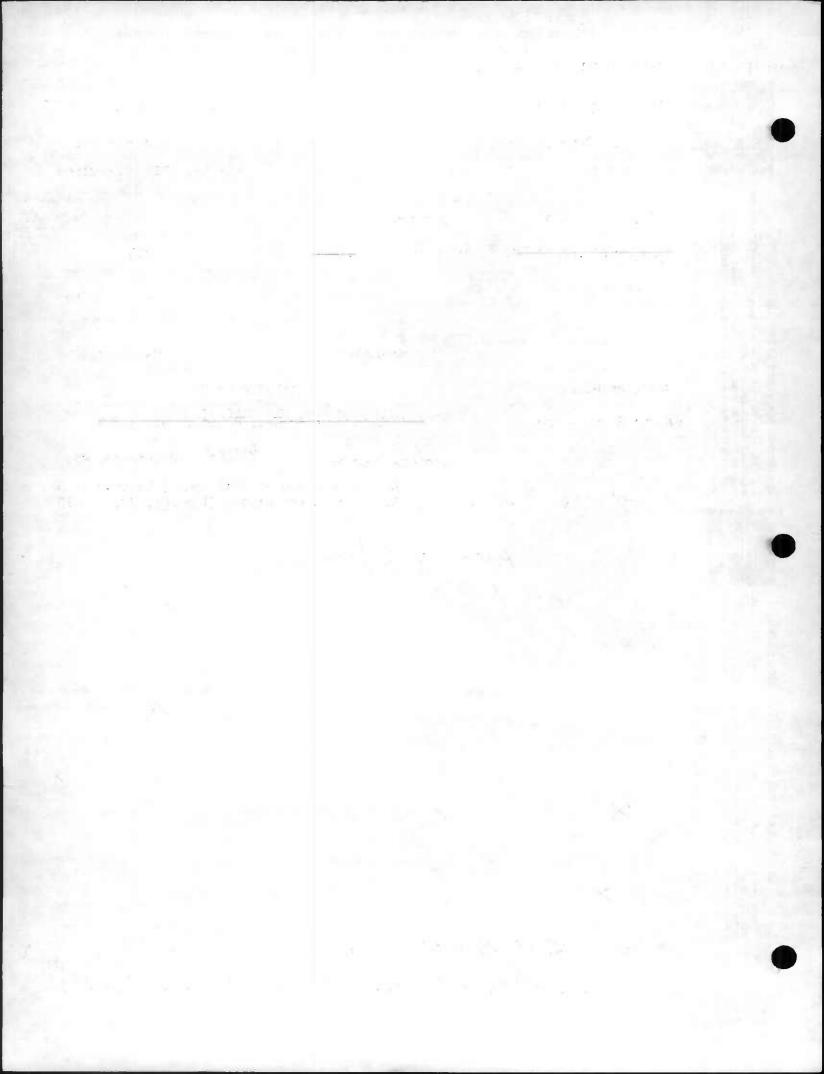
State Registrar 29b. Signeture and title of certifier

31. Dete filed (Month, Day, Year)

30. Name and eddiness of person who completed cause of deeth (Item 23e) (Type, Print)

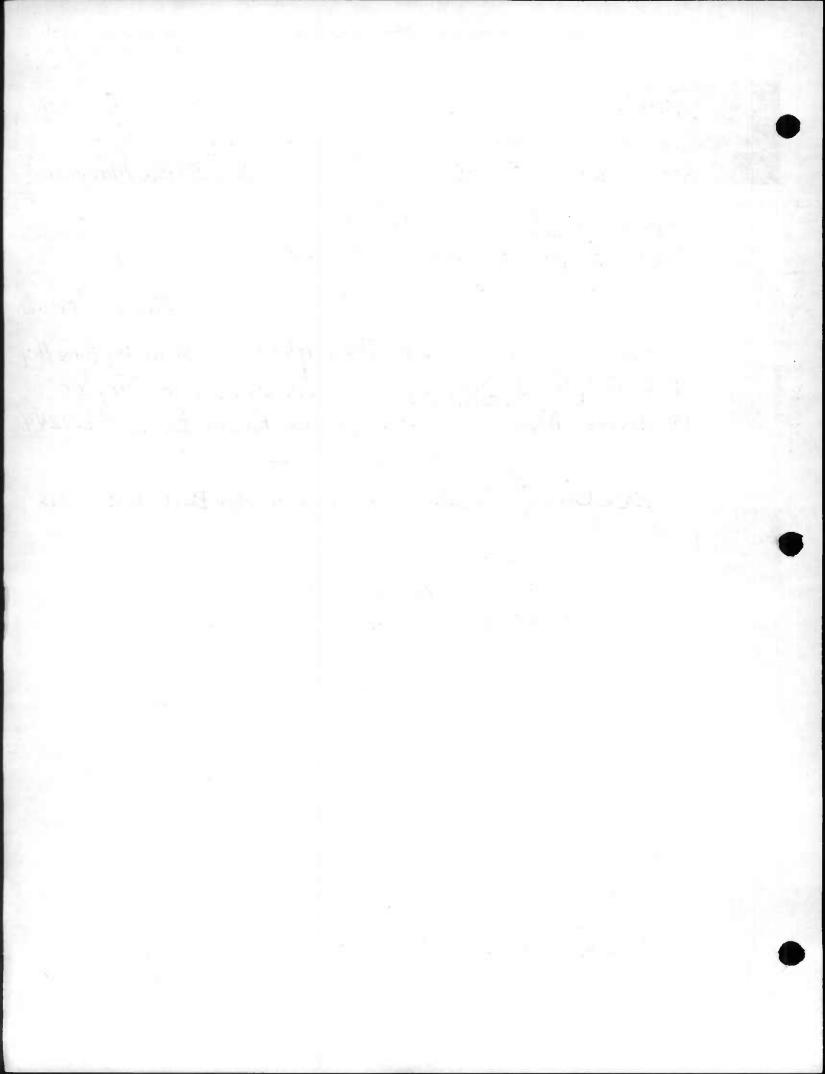
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32. Registrer's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

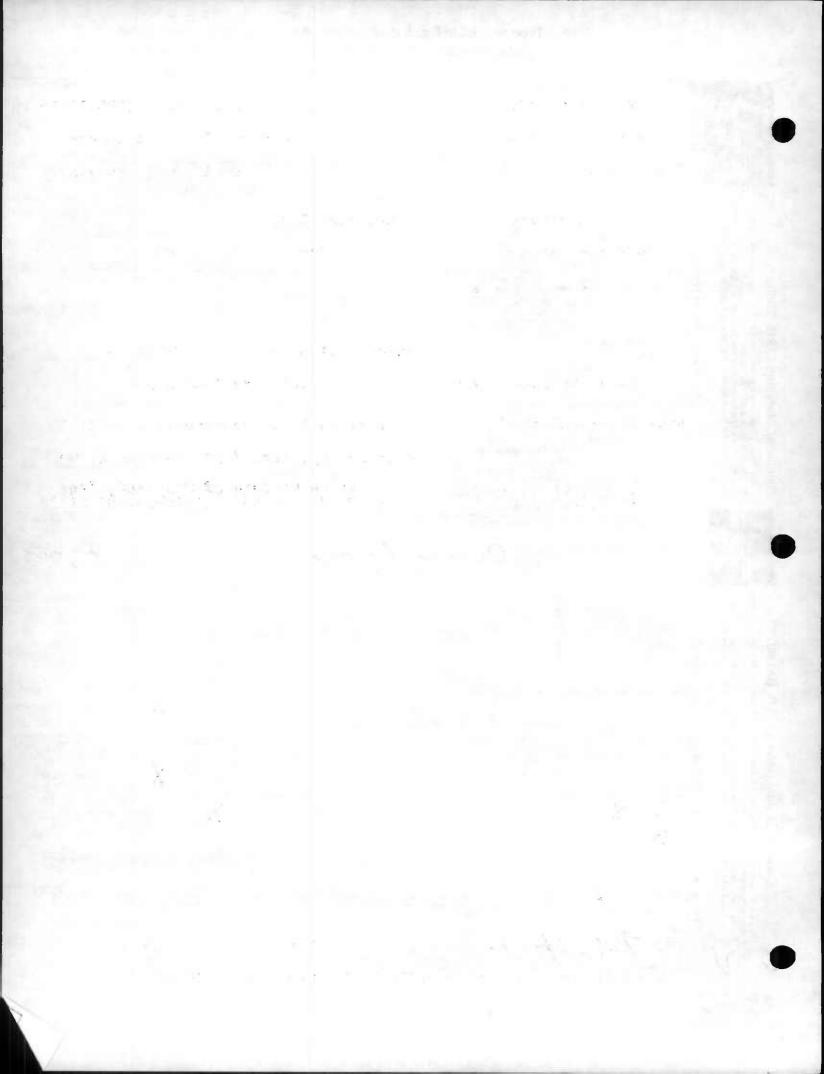
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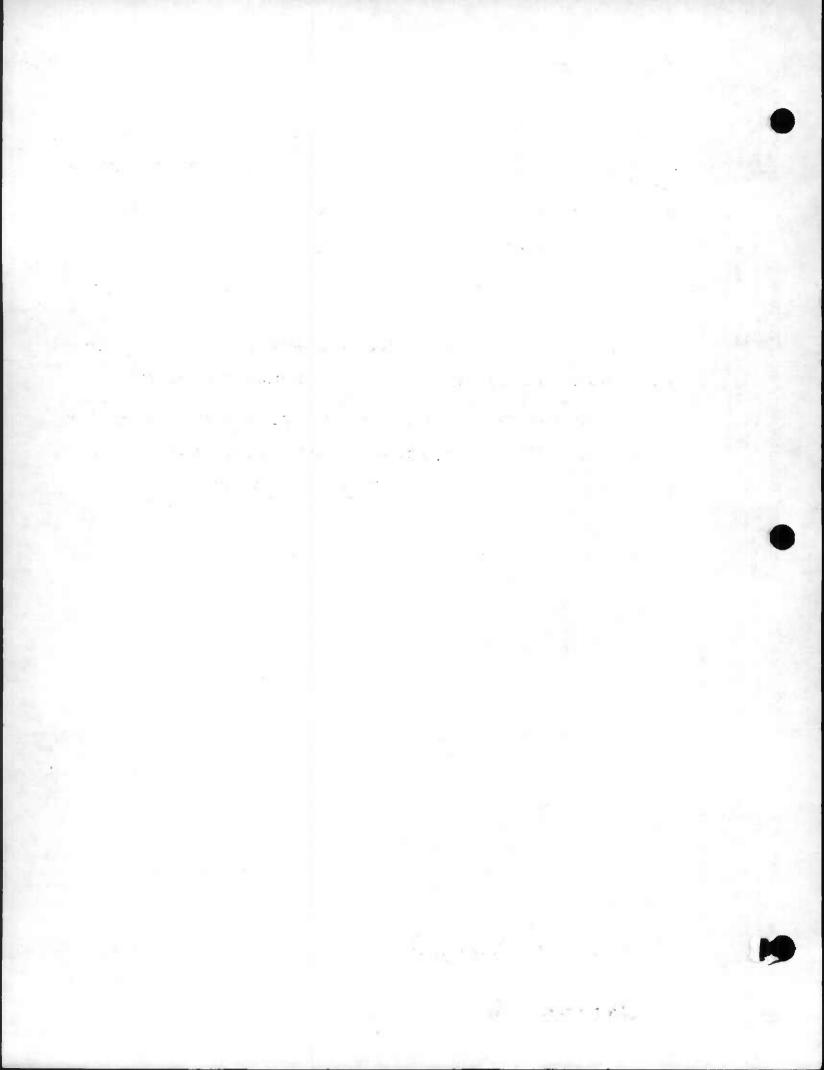
State of Maryland / Department of Health and Mental Hygiene

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Ind 21215-0020 be filed within 72 hours efter deeth with the Meryland	in of Health and Mentel Hygiena. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at or other traumatic event, the Medical Examiner must be notified at or other traumatic event, the Medical Examiner must be notified at or other traumatic events.	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	Jucation			cupation ne during most of wo ired)	rking		usiness/Industry			
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	2	30. Name and eddress of person who Robert Shepard,	M.D. 6569 No	rth Ch	pe, Print) arles St.	Baltimor	e, MD 21	204				
	State	31. Date fited (Month, Day, Year)	32. Begistrar's SI	gnatura	1							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 27/56 Certificate of Death 2. Data of Death 3. Tima of Death AUGUST 30, 1998 ear **Physician** ADAM S. MARTINEZ 1:06 PM. /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death **Examiner** JOHNS HOPKINS HOSPITAL BALTIMORE N/A If Under 24 Hrs. If Under 1 Year 8. Data of Birth (Month, Day, Year) JULY 25, 1977 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 9. Birthplace (Stata or Foreign **Funeral** Months Days Hours 1 M 2 F 216-94-2798 21 MARYLAND Yrs **Director** Usual Rasidanca of Dacedant the Marylend 10b. County 10c. City, Town or Location 10d. Insida City Limits Show r than "natural", or items 23s or 28s-f sho the Medical Examiner must be notified at 1 ☐ Yas 2 ☑ No Director MARYLAND BALTIMORE RANDALLSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 CINNAMON CT. CINNAMON CIRCLE APTS. 21133 U.S.A. Funeral 14. Race - Amaricen Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 12. Was Decadant Evar in U.S. 72 hours after 1 ☐ Yes 2 XNo If Yas, Giva Yaar or Datas: 1 Nevar Married 2 ☐ Married 21215-0020 "natural", or WHITE 1X Yas 2 No Specify: CURAN Specify: 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Spacify only highast grada complated) I Hygiene. Elamantary/Secondary (0-12) Collega (1-4or 5+) ELECTRICIAN APPRENTICE ELECTRIC COMPANY 9th GRADE marked other Baltimore, Maryland 17. Fathar's Nama (First, Middla, Last) 18 Mothar's Nama (First Middle Maiden Sumama) . Peges 1 end 2 should be fili-ment of Health end Mentel H-lant: If Nem 27 Is marked oth-jury or other traumatic even Be GERALD MICHAEL MARTINEZ, SR. BERNADETTE ANN BROWN 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) BERNADETTE SMITH (MOTHER) 8020 RITCHIE HIGHWAY- PASADENA, MARYLAND 21122 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 Buriel 2 Cramation 3 Ramoval from State 4 Donation 5 Other (Specify) Department of Important: If any Injury or pace. BALTO/WASHINGTON CREMATORY 9-3-98 LAUREL, MARYLAND 21. Signatura of Funeral Sarvica Licensea 22. Nama and Addrass of Facility HUBBARD FUNERAL HOME INC. Timothy M. Burdyck 4107 WILKENS AVENUE-BALTIMORE, MARLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intarval Batween Onset and Death **Physician** Immediata Causa (Final disaasa or condition rasulting in daath) /Medical CONTACT GUNSHOT WOUND TO HEAD Examiner Dua to (or as a consequence of): Examin physicien and the burial-transit certificate be executed Sequantially list conditions, if any, laading to immadiata causa. Enter Underlying Cause (Disaasa or Injury that initiated avants rasulting in death) Last Dua to (or as a consequenca of): Box 68760 Physician/Medical Dua to (or as a consequence of): 50 980 0.0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by should be detec 1 Yes 2 No 3 Probably 4 Unknown The law requires thet Records, þ 24b. Wara autopsy findings available prior to complation of cause of death? Be Completed 24a. Was an autopsy parformed? page 1 X Yas 2 No 1 X Yas 2 □ No of Vital 25. Was casa rafarred to medical 26. Placa of Death (Check only ona) Hospital: 1 X Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidence 8 Othar (Specify) XXYas 2 No edicai Certification: To this 27. Mannar of Daath 28a. Data of Injury (Month, Day Year) 28b. Tima of Injury 28d. Dascribe how injury occurred 28c. Injury at Work? Division Hospital or Attending 24 hours after death. 5 Panding Invastigation 1 Natural 1 Yas ZANO AUG.30,1998 0222 SUBJECT SHOT 2 Accident Director: / 6 Could not be 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 801 SILVER CREEK RD. BALTO. MD 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) Homicida HOUSE To the Hospital within 24 hours a To the Funeral I completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

**To Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Cartifiar (Check only one) 29d. Data signed (Month. Day, Year) 29b. Signature and title of certifiar 29c. Licensa number O.C.M.E. Jenuary 22,1999 re-1ssued_ 30. Nama and addrass of parson who complated cause of death (tem 23a) (Type, Print) J. Laron Locke M.D. 111 Penn Street, Baltimore, Maryland 21201 31. Data tilad (Month, Day, Year) watrar's Signatura State JAN 2 7 1999 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

MARIE "MCBRIDE" MATTHEWS

State of Maryland / Dej

partment of Health and Me	ental Hygiene	27	-	[4000
ertificate of Death	Reg. No.	6. 1	İ	U	-

							Ce	rtificate	of	Death	R	eg. No.	lane or	1101	
	Dhuaisia		I. Decedent's Name (- 11			2. Date of Deet Month	h Day	Year	3. Time of Death	
	Physician /Medica		Marie T	. McBr	ide						SEPTEMBE		1998	2358PM	
	Examine		a Facility Name (If n	ot institution, give	street and numb	er)			4	4b. City, Town, or L	ocation of Death	4c. County	of Death		
	,		UNION HOSE	PITAL E.	R.					ELKTON		CECIL	COUN	TY	
	Funeral Director	67	107-30-		ex 7. □M 21X1 F	Age (In yrs 59	. last birthday, Yrs.		Year Days	1f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Jul. 1		Coun		
	P .		Jsual Residence of D			140- 0	. T						1.		
	ehyle ehov		IOa. State 1	0b. County		10C. C	ity, Town or L	ocation					1	0d. Inside City Limits 1	
	72 hours efter death with the Meryland natural, or items 23s or 28s-f show aces Examiner must be notified at the Average Directors.		NY		York		New	York						3/2	
	with the party of	5	10e. Street and Numb		Yb waab			10f. Zip C			1	Og. Citizen of			
	a 23	2	89 Chris	topner s			10 40					United			
	item item	5	11. Maritel Status	O Married	12. Was Decede	s?	J,S. 13.	If Yes, specify	Cuba	lispenic Origin? (Sp an, Mexican, Puerto	Rican, etc.)		e - Americ ck, White,		
20	or eff.		Never Married 3 ☐ Widowed 4		1 ☐ Yes 27 If Yes, Give Year or Date			1 ☐ Yes 25	OV J K	Specify:		Specif	w: Wh	nite	
8	houn	2 -		5. Decadent's Ed			16e Dece	edent's Usual (Occur	etion		16b. Kind of B	ueinace/Inc	dueto	
5	n 72		(Specify	only highest gra	de completed)		(Give	kind of work DO NOT use	done i	during most of work	ring	TOD. KING OF B	U3111033/1110	lustry	
re, Maryland 21215-0020 I lend 2 should be filed within 72 hours efter death with the Merylen filealth and Mentel Hygiene. The marked other than "natural", or items 23e or 28e-f show other traumatic event, the Medical Examiner must be notified at To Be Commissed by Filmeral Director			12th Gra	_ ' ' '	College (1-4-	or 5+)		Home		•			Own	Home	
		5	7. Father's Name (Fi		.,,		1				r's Name (First, Middle, Maiden Surname)				
			Thomas M	cBride						Anna	Goodwin				
			19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, S											Code)	
			Thomas Mc	Bride /	Brother										
other tr	2	20a. Method of Dispos		DICONCI	20b.	Placa of Disp	osition (Name	of		Date	20c. Location	City or To	wn, State		
m 0	0 80 = 2		1 Burial 2 0 4 Donation 5	Cremation 35	Removal from Sta	IIA		Cemete			8,1998	Woods	ide,	NY	
H			21. Signature of Fune			Doda	, Jr. 2	2. Name and	Addre	ss of Facility					
ä	permit. Depertrimports any Injury.		1 CT	700	1.00	\supset	Cł			Stevens				3 01000	
		1	23a. Part1. Enter the	disease or com	lications that Yau	ead the dea							Maryı	Land 21230 Approximate	
	Dharatatan		shock, or heart f	ailure. List only	one cause on eac	h line.	in. Do not on	110 1110 111000	or dyn	ig, 30011 03 001 0100	or rospiratory arr	301,	Interval Between Onset end Deeth		
γ.	Physician //weurcar		Immediate Cause (Fir	nai	MI	m 00 0	Shan	. 004	20	iovoscen	00 0				
1	Examiner	1	disease or condition resulting in death)		e. Alec				, (,)	wypseu	1250 D	36172			
	ة السطا	5				Due to (or as a conse	quence of):							
	cate be executed physician and the buriel-transit				b	Due to /							-		
,	exect lel-tra		Sequentially list condi f any, leading to imme cause. Enter Underly	tions, ediate		Due to (or as e conse	quence or):					1		
290	9 / 85 -		Cause (Disease or inj hat initiated events	ury	c	Duo to /									
68760,			resulting in death) Las	st		00 10 (1	or as a conse	querice or).							
ŏ	nding use e				d										
ω.	at the death of by the etternetached for use	F	Part II. Other significa	nt conditions co	ntributing to deat	hut not re	sulting in the I	ınderiving çau	se div	en in Part I	23b. Did to	bacco uaa co	ntribute to	the cause of death?	
P.0	that the dended by the eached of		•									s 2□No	3 □ Prol	11	
	es tha igned be de		DABETES	hemia	VS_SET	curs	Dryo	MAN							
Records,											24e. Was e		24b. We	ere eutopsy findings ailable prior to	
00	law re	-									periori	1001	CO	mpletion of cause deeth?	
E	e de de de de de de de de de de de de de										16/10	s 2 No	17	Yes 2□ No	
Viital	intificat ctor. p	2	25. Was case referred	to medicel						26. Place of Deal				3 100 22 110	
>	Physician: this certific ral director.	1	examiner? 1 ⊠ Yes 2 □ No		Hospital:	ationt 21X	ER/Outpatie	nt 3 DOA	Oth	er:	ome 5 Reside		er (Specifi	v1	
ō	orthic eral c		7. Manner of Deeth		28a. Date of I	njury	28b. Time o		: Injur		28d. Describe ho			,	
Division	Attending in death. actor: After by the fune		1 ☐ Natural 2 ☐ Accident	5 Pending investigation	(Montn,	Day Year)	Injury	М		Yes 2□No					
/IS	or Attendation of Att		3 Suicide	6 Could not be	28e. Place of			reet, factory, o	office		28f. Location (St	reet and Numl	er or Rura	i Route Number,	
5			4 ☐ Homicide		building,	etc. (Speci	Ty)				City or Towr	, 51616)			
										ne, date and place,					
	ne Hospi n 24 hou ne Fune pletely fil edical		(Check only 2)	Medical Exam	iner: On the basis end manner	of exa <i>m</i> ina stated.	ation and/or In	vestigation, in	my o	pinion, death occur	red et the time, de	ete and place,	and due to	the cause(s)	
	within 24 To the H complete		9b. Signature and titl	e of cartifier	1/			29c. l	icens	e number	2	9d. Date signe	d (Month,	Day, Year)	

O.C.M.E.

SEPTEMBER 02, 1998

ge and address of person who completed cause of deeth (Item 23e) (Type, Print)

SKYDNEN Commu Mull1 Penn Street, Baltimore, Maryland 21201

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature

West File of State of State 5 3 AP 1 1 ned Age in the thirty of a little to the second se The state of the second

Physician /Medical Examiner

Examiner

Physician/Medical

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Completed

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Certification:

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Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23e or 28s-f show the Medical Exeminer must be notified at

Director

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by

Completed

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after

Hygiene.

permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiene Important: if item 27 is marked other tha any injury or other traumatic event, thall phose.

The law requires that the death certificate be executed signed by the a peen certificate has this

Division of Vital Records, or Attending Physician: within 24 hours efter death.

To the Funeral Director: After thi
completely filled in by the funeral

Roggen 31. Dete filed (Month, Day, Year) State SEP 0 4 1998 Registrar

1. Naturai

2 Accident

4 Homicide

(Check only one)

29b. Signature end title of certifier

1 Koggen

3 ☐ Suicide

29a. Certifier

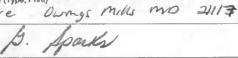
5 Pending

investigation 6 Could not be determined

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

21 Crossroads Drive 32. Registrer's Signeture

28e. Pleca of Injury - At home, larm, street, factory, offica building, etc. (Specify)



1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and pleca, end due to the ceuse(s) end menner as stated. 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, deeth occurred at the time, date end piece, and due to the cause(s) end manner stated.

29c. License number

1 Yes 2 No

D 35844

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

1998

September 02

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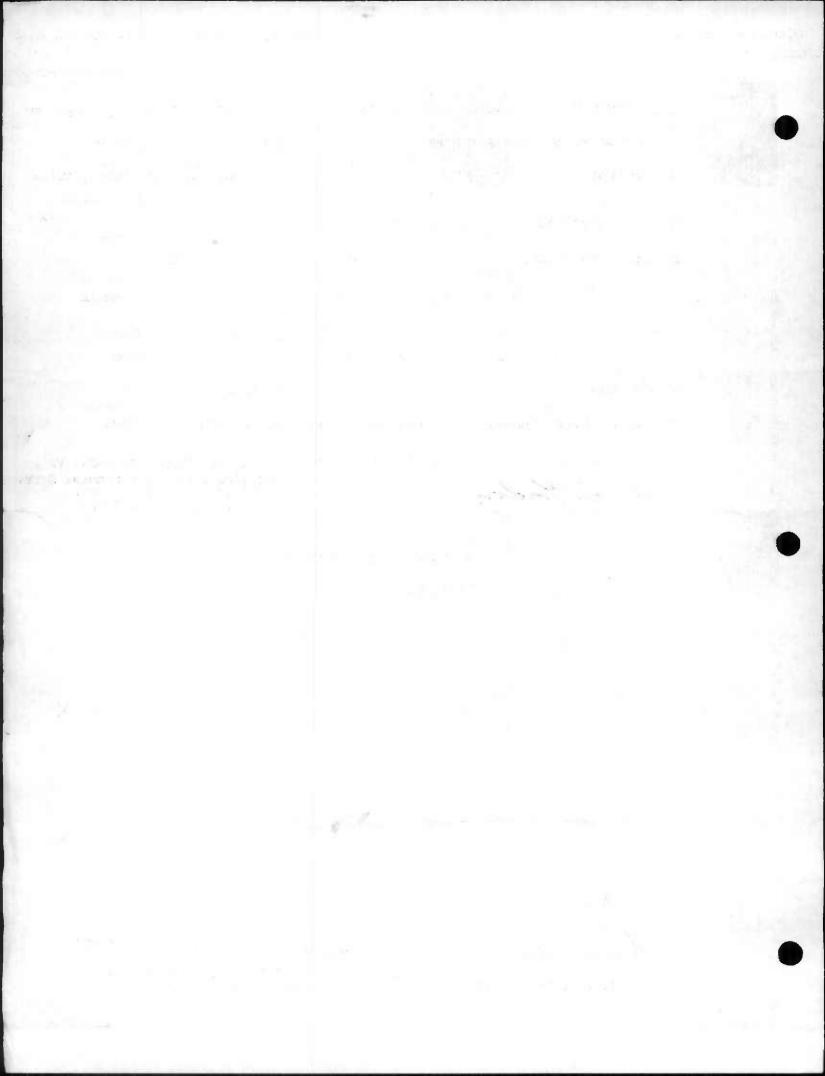
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Harry Contract

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		Decedent's Name (First, Middle, La	st)	7	Certificate of		2. Date of De		3. Time of	f Death
Physic /Medi		FRANCINE	LONG	****	NIMMO		Month AUG 2		Year 8:4	4 PM
Exami		4a. Facility Name (If not institution, giv	re street and number)			4b. City, Town, or Lo				1
		NATIONAL NAVAL	MEDICAL C	ENTER		BETHE			ONTGOMERY	
Funeral Director		200-46-7428	TM SEME	(In yrs. last bir 43	thday) If Under 1 Year Months Deys		8. Date of Bir (Month, Da May 1	th ly, Year) 2, 1955	9. Birthplace (State of Country) Pennsylva	or Foreign ania
yland		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Location				10d. Inside Ci	ity Limits
Mar Mar	tor	VA Staffor	rd	Falmo	uth				1 ☐ Yes	2 🔀 No
or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of W	hat Country?	
th w	Je.	14 Little Creek 1	Lane		22405			USA		
n 72 hours after deeth with the Maryland *natural", or items 23s or 28s-f show edical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Merried 3 □ Widowed 4 □ Divorced	12. Wes Decedent I Armed Forces? 1 XYes 2 N If Yes, Give Year or Dates:	ever in U,S. UNK	13. Wes Decedent of If Yes, specify Cul		ecify Yes or No Ricen, etc.)	14. Race Black Specify:	- American Indien, k, White, etc. White	
within ane. than	Completed	15. Decedent's E. (Specify only highest gra	ducation ade completed) College (1-4or 5	+)	Decedent's Usual Occu (Give kind of work done life. DO NOT use retin	ipation a during most of worki ad)	ing	16b. Kind of Bus		
H Pyg		17. Fether's Neme (First, Middle, Last,			Homemaker	18. Mother's Name	(First, Middle	Own He	The state of the s	
d is o	To Be	Bernard Long				Rhoda M			,	
d 2 should by th end Menta 7 is marked traumatic ex	F	19a. Informent's Name/Reletionship (Type, Print)	19b	. Mailing Address (Stree			er, City or Town, S	State, Zip Code)	
		Richard E. Nimmo	, husband	1.	4 Little Cr	eek Lane,	Falmou	th, VA 2	2405	
ages ant of t: If it y or o		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification)		20b. Place o cemete	Disposition (Name of ry, crematory or other plantill Cemete	ace)	Date	20c. Location - 0	City or Town, State	7A
permit. F Departme Importan any Injur		21. Signature of Funeral Servica Licer	andon			ess of Facility Mul 162	lins &		n Funeral vis Hwy.	
Sertificate be executed ding physician and se es the buriel-frensit	/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initileted events resulting in death) Last	b	Due to (or as a LEUKEMI	REBRAL HEMO consequence of): A consequence of): consequence of):	PRRHAGE				
death cer e attendin	clan	D . H Ou								
that the ded by the	/ Physician/N	Part II. Other significent conditiona c	ontributing to death bu	t not resulting in	n the underlying cause g	iven in Part I.			3 Probably 4	of death? Unknown
e law requires that the death cert hes been signed by the attendin je 2 should be deteched for use	Completed by							an eutopsy ormed?	24b. Were autopsy to eveilable prior to completion of death?	to
E se se	S						10	Yes 2 No	1 ☐ Yes 2 ☐	No
Physician: The this certificate ral director, per	Be	25. Was case referred to medical examiner?	Hospital:	110000		26. Place of Deeth	(Check only o	one)		
dis A	ition: To	1 Yes 2 No 27. Manner of Death Naturel 5 Pending 2 Accident Investigation	28a. Date of Injur (Month, Day	y 28b. 1	ime of hjury 28c. Injury			dence 6 Othe		
nding Ph th. :: After th e funeral	400	3 ☐ Suicide 6 ☐ Could not b	28e. Place of Inju	ry - At home, fa . (Specify)	rm, street, factory, office		28f. Location (. City or To		er or Rural Route Num	ber,
or Attanding ster death. Director: After in by the fune	Certific	4 Homicide	Auto-							
or Attanding ster death. Director: After in by the fune	edical Certification:	29a. Certifier 1 Certifying Ph	ysician: To the best o	examinetion an	, death occurred at the t d/or investigation, in my	ime, date end place, a opinion, death occurre	and due to the ed at the time,	ceuse(s) end men date and place, a	nner es stated. nd due to the cause(s	;)
To the Hospital or Attanding Ph within 24 hours effer death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier (Check only 2 Medical Exam	ysician: To the best onliner: On the basis of	examinetion an	d/or investigation, in my	ime, date end place, a opinion, death occurrence number	ed at the time,	date and place, a	nner es stated. nd due to the cause(s	3)
or Attanding ster death. Director: After in by the fune	edicai	29a. Certifier (Check only one) 1 X Certifying Ph 2 Medical Exam	ysician: To the best onliner: On the basis of	examinetion an	d/or investigation, in my 29c. Licen	opinion, death occurre	ed at the time,	date and place, a	nd due to the cause(s	3)



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State of Maryland / Department of Health and Mental Hygiene

					Certificate o	f Death	R	eg. No.	Z /	bU
Г	Physici	an	1. Decedent's Name (First, Middle, Last)				2. Dete of Deel			ot Death
	/Medic		Kum Sun Pang					23°, 1998	1:2	5 PM
	Examin	er	4e. Facility Neme (If not institution, give street end number)			4b. City, Town, or I	Location of Deeth	4c. County of		
ш			100 Denson Dr.	1 1171	H Haday 1 Va	Severn			Arundel	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (<i>In yrs.</i> 220−84−6790 1□ M 2 F 57 Usuel Residence of Decedent		hday) If Under 1 Ye Months Dey		8. Dete of Birth (Month, Dey) FEB. 1,	1941 9	Birthplace (State Country) South K	
	be filed within 72 hours after death with the Menyland that hygiene. Id other than "natural", or items 23a or 28s-f show event, the Medical Examinet must be noticed at	tor	· · · · · · · · · · · · · · · · · · ·		or Location				10d. Inside	City Limits
	or 284	Director	10e. Street end Number		10f. Zip Code)	1	0g. Citizen of Whe	et Country?	
	23a c	ral C	100 Denson Dr.		2114	14		South	Korea	
	r items	Funeral	11. Merital Stetus 12. Was Decedent Ever in U Armed Forces? 1 □ Never Married 2 ☒ Merried 1 □ Yes 2 ☒ No	,S.		f Hispanic Origin? (S uben, Mexican, Puert	pecify Yes or No- o Ricen, etc.)		Americen Indien, White, etc.	
2-0020	al', o	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Detes:		1 □ Yes 20X(N	lo Specify:		Specify:	Asian	
ה ה	72 honatur	Be Completed	15. Decedent's Education (Specify only highest grade completed)	18e.	Decedent's Usual Occ	cupation ne during most of wor	kina	16b. Kind of Busin	ness/Industry	
V	within ne. han "	mpl	Elementery/Secondary (0-12) College (1-4or 5+)		(Give kind of work doi life. DO NOT use ret	ired)		F 10		
0	al Hygie other I	S	12 17. Fether's Neme (First, Middle, Lest)		Cook	18. Mother's Ner	ne (First, Middle, I	Food Sei	rvice	
Maryland	d fall o	To Be	Ki Bo Son			Bong Su		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
	2 should be and Mental is marked raumatic ev	-	19e. Intorment's Neme/Relationship (Type, Print)	19b.	Meiling Address (Stre			; City or Town, Sta	ate, Zip Code)	
Š	s 1 and 2 should f Health and Mer from 27 is marke other traumatic		Chu Pang – son	100	Denson Di	., Severn	, Md. 2	1144		
9	of He of He f Rem r oth		20a. Method of Disposition 20b. Fig. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State	Plece of cemeter,	Disposition (Neme of y, cremetory or other p	plece)	Dete	20c. Location - Cit		
	. Peg ment tant: I		- A	dowr	ridge Memoi	rial Park	0/25/98	Elkrid	ge, Md.	
paltimore	permit. Peges 1 end 2 Depertment of Health 1 Important: if Item 27 is any injury or other tra ance.		21 Signature of Funeral Historica Licensia		Gary L. Ka	dress of Facility Bufman Fun	eral Hom	e @ Meado	owridae	MP. Ind
	TD T & C		Thurs & Seles		7250 Wash:	ington Blv	d., Elkr	idge, Md	. 21075	
			231 Put1. Enter the disease, or complications that caused the deat stock, or need feiture. List only one ceuse on each line.	h. Don	ot enter the mode of c	lying, such es cerdiac	or respiretory err	est,	Approxim Intervel B Onset an	etween
	Physician /Medical		Immediate Ceuse (Final	+ +	-4:1 /	1/2 /5.20	3 Ca. 17.		1	nonths
	Examiner		disease or condition resulting in deeth) e	451	GTIL (norung	UCGYCIY	10m9	7	6191101
-	70 .52	Iner		,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						
	icete be axecuted physician and s the burial-transit	kam	Sequentially list conditions, Due to (c	or es e c	onsequence of):	•				
S S	be ax ician burial	ai	Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury c.							
00/00	centificete be axecuted inding physician and use as the bunal-transit	edicai Examiner		rasac	onsequence of):					
ממא	nding use a	N/M	d							
0	daath le ettan ed for u	sicia	Pert II. Other eignificant conditions contributing to deeth but not res	uitina In	the underlying ceuse	given in Part I.	23b. Did to	bacco use contri	bute to the caus	e of death?
ر ا ا	that the	by Physician/M						/	☐ Probably 4	
ecolus,	lew requiras that the death cer as been signed by the ettandir 2 should be detached for use	Completed b					24a. Wes e		24b. Were eutops available pric completion o	r to
ב	8 8 8	dmo						es 2 No	of deeth?	
		Be Co	25. Wes cese referred to medical			26 Piece of Dec	1 □ Ye	VI = 5500.51	1 ☐ Yes 2	No No
>	yslcie is cert direct	To B	examiner?	ER/Out	petient 3 DOA	Whor:		ence 6 Other	(Specify)	
5	Attending Physician: It death. ector: After this certific by the funaral director.		27. Member of Deeth 1 Netural 5 Pending 28e. Dete of Injury (Month, Dey Yeer)	28b. T	ime ot 28c. In			ow injury occurred		
5	eath. or: Af the fu	catic	2 Accident Investigation 3 Suicide 6 Could not be			☐ Yes 2 ☐ No				
5	Direct In by	Certification:	4 Homicide determined 28e. Piece of Injury - At h	ome, tar y)	m, street, tectory, offic	e	28t. Location (Si City or Town	reet and Number n, State)	or Rural Route Ni	ımber,
1	Funeral Funeral		29a. Certifier 1 Certifying Phyalcian: To the best of my kno	wiedge.	deeth occurred at the	time, dete and place	end due to the c	ause(s) end menn	er es steted	
	Fur Fur	edical	(Check only one) 2 Medical Examiner: On the basis of examine end menner steted.	tion end	Vor investigetion, in m	y opinion, deeth occu	rred et the time, d	ete end place, and	due to the ceuse	e(s)
	within To the comple	Σ	29b. Signeture end title of certitier			ense number	2	9d. Date signed (I	Month, Day, Year,)
1	10		Men-sur / trick M.	0		52257		8/31	198	
	(-		30. Neme end eddress of person who completed cause of deeth (Item	n 23a) (Type, Print)	olfe Sti		1 4-		1
			Wen-50n H57en 600 31. Dete filed (Month, Dey, Yeer) 32. Registrar's Signe) N	lorth W	olte sti	reel L	Jalli mo	ve, N	10
	Sta Registra		SEP 0 4 1998	Aut o	-					
DHA	AH 16 Rev 6/95		CEI VI 1030	P	Apocks					



Physician /Medical Examiner

Funeral

Director

permit. Pages 1 end 2 ahould be fired within 72 hours atter death with the marytan Department of Health end Mental Hydena. Important: if item 27 is marked other than "natural", or itema 23a or 28a-f ahow why injury or other traumatic avent, the Medial Esteritos must be notified at once.

Physician /Medical Examiner

To Be Completed by Funeral Director

Plea	ase Type or Pr State of M	Maryland / D	Department of	f Health a	and N		_	ible.		
			Certificate of	of Death		R	leg. No.	6/101		
1. Decedent's Name (First, Middle	e, Last)					2. Date of Deet Month	th Dev	3. Time of Death		
John J. Petra:	itis, Sr.					Septemb	-	1998 9:40 am		
4a Facility Name (If not institution	n, give street and numbe	er)		4b. City, To	wn, or L	ocation of Death	4c. County			
VA Maryland Hea	alth Care S	tystom		Perry	Poi	int	Ceci			
5. Social Security Number	6. Sex 7. /	Age (In yrs. last birti	thday) If Under 1 Ye	ear If Under 2	24 Hrs. Min.	8. Dete of Birth (Month, Dey,	1	9. Birthplace (State or Foreign		
215-12-5921	123M 2□ F	77 Y	Yrs. Months Da	ays Hours	Mis I.	June 24	,1921	Maryland		
Usual Residence of Decedent										
Maryland Balt	timore	10c. City, Town						10d. Inside City Limits 1 ☐ Yes 2 ☑ No		
10e. Street and Number			10f. Zip Cod	ie		1	Og. Citizen of	Whet Country?		
5105 Circle Pla			2122				U.S.			
11. Marital Status	12. Was Deceder Armed Forces	95?	13. Was Decedent of If Yes, specify C	of Hispanic Original Cuban, Mexican	gin? (Sp	pecify Yes or No- b Rican, etc.)		ce - American Indian, eck, White, etc.		
1 ☐ Never Merried 2 ☑ Merr 3 ☐ Widowed 4 ☐ Divorced	Tied 1 NYes 2	II WW	1 ☐ Yes 2 ဩ N				Specif			
	nt's Education est grade completed)	16a.	Decedent's Usuel Oc (Give kind of work do	cupation	o of word	Lina	16b. Kind of B	Business/Industry		
Elementary/Secondary (0-12) 9TH GRADE	College (1-4o	or 5+)	ING. DO NOT USE TELE SELF-EMPLO	tired)	UI WOLL	ling	CAR S	SERVICE		
17. Father's Name (First, Middle,	Last)			18. Mothe	r's Nam	ne (First, Middle, M	Vaiden Sumer	me)		
Benedict Petra:		100				Banjuas	On a Tour	C 1- 7- 0-43		
19a, Informant's Name/Reletions			. Mailing Address (Str							
Evelyn M. Petra	aitis (Wire	-	105 Circle		- A)		-			
20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 4 ☐ Donation 5 ☐ Other (S)		cemeter	t Disposition (Name of ny, crematory or other p n Park Cemo	plece)	1	Date 9/4/98	20c. Location Baltin	- City or Town, State		
21. Signature of Fugieral Service	. Shar	non	22. Name end Ad Hubbard 1 4107 Will	dress of Facility Funeral	Hor	me, Inc.	ore, M	Aryland 21229		
23a Part Enter the disease, or heart feilure. List	complications that caus only one cause on each	ed the death. Do n i line.						Approximate Interval Between Onset and Death		
Immediate Cause (Finel disease or condition resulting in death)	a. Pancr		stric Carci	inoma			5.5	2 Years		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b	Due to (or es e c	consequence of):					t		
Cause (Disease or injury that initiated events resulting in death) Last	С	Due to (or as a co	onsequence of):							
	d									
Part II. Other algnificant condition Diabetis Melli		but not resulting in	the underlying cause	given in Pert I.			obacco use co ∕es 2⊠ No	ontribute to the cause of death? 3 Probably 4 Unknown		
	Cus					24a. Was e		24b. Were autopsy findings available prior to		
Hypertension							es 20XNo	completion of cause of death?		
25. Was case referred to medical	4			26 Place	~ Chas	ath (Check only on				
examiner?	Hoenital:	2 EB40	2 DOA	Other:				1040-		
27. Manner of Death 1 ⊠Natural 5 □ Pendin	79	njury 28b. T	Time of 28c. In	4 XI Nul Injury at Work? 1 □ Yes 2 □ I		lome 5 ☐ Reside 28d. Describe ho				
2 Accident 3 Suicide 6 Could r 4 Homicide	not be 28e. Place of I	Injury - At home, far , etc. (Specify)	rm, street, factory, offi			28f. Location (Street and Number or Rural Route Number, City or Town, State)				

Medical Certification: To Be Completed by Physician/Medical Examiner within 2s frough effer death.

To the Perfect Director: After this certificate has been signed by the attending physicien end complete the perfector, page 2 should be detached for use as the buriel-transit To the Rospital of Attending Physician: The law requires that the death certificate be associted Division of Vital Records, P.O. Box 68760,

6+1 State Registrar

DHMH 16 Rev 6/95

29a. Certifier (Check of one)

29b. Signati

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ani

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

151094-1 9/1/98

Melecia A. Sar 31. Date filed (Month, Day, Year) Santos, M.D., VA Maryland Health Care System, Perry Point, MD

32. Repistrar's Signature

9. April 1

Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** September Grace Papa /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilcrest Center Towson Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 1 F Yrs. 88 Director 216-16-4619 Feb 7, 1910 New Jersey Usual Residenca of Decedent 10c. City, Town or Location 10a State 10b County 10d, Inside City Limits 7 is marked other than "natural", or hams 23s or 28s-f show traumetic event, the Medical Examinar must be notified at 1 Yes 2√2 No MD Baltimore Parkville Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8810 Walther Blvd 21234 USA Funeral 12. Was Decadent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Baca - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 X No Specify: Specify: þ White 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife 10 Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Be permit. Pages 1 and 2 should be 1 Department of Health and Mental Important: If Item 27 is marked or Beneddette LaCanfora Mary Simmaroni To 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 11 Stable Gate Ct. Joseph Papa Jr. Baltimore, MD 21128 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stata Sept 5 5 1 XBurial 2 ☐ Cremation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith 1998 Baltimore, MD 21. Signature of Funeral Sarvice Licensee 22. Name end Address of Facility
Connelly Funeral Home of Dundalk 7110 Sollers Point Rd 23a. Part1. Enter the disea in, or complications that caused the death. On not enter tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death **Physician** transitional cell cancer of Bladder
Due to (or as a consequence of): /Medical Immediate Cause (Final disease or condition resulting in death) 4 months Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 Physician/Medical Due to (or as a consequenca of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. the 23b. Did tobacco usa contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed peeu completion of cause of death? has 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Hoggs Injury at 28d. Dascribe how Injury occurred 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) funeral 27. Manner of Deeth 28b. Time of Certification: 28c. Injury at Work? 1 Naturel 5 Pending death. 1 Yes 2 No 2 Accident Investigation or Attend after death Director: 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signatura and little of certifier 29c. Licansa number

N. Charles St. Balto. Md 21707

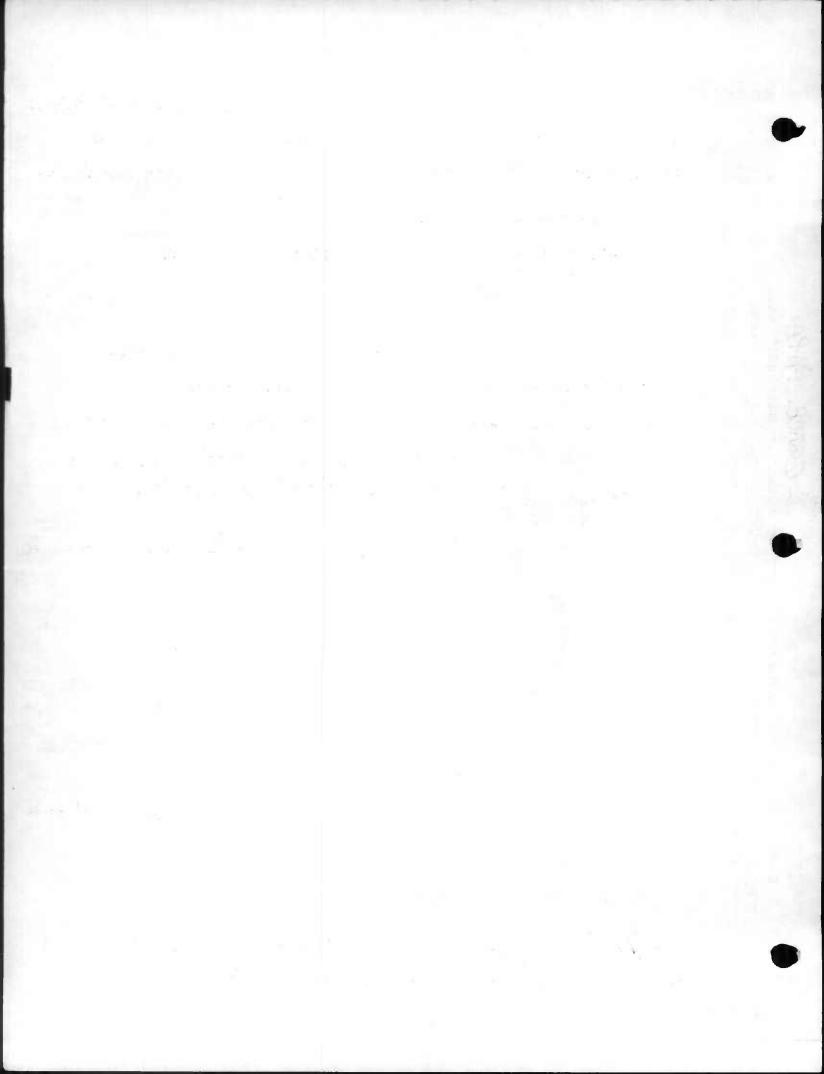
State Registrar

A.Rile 31. Date filed (Month, Day, Year) 32. Registrar's Signature 1998

6701

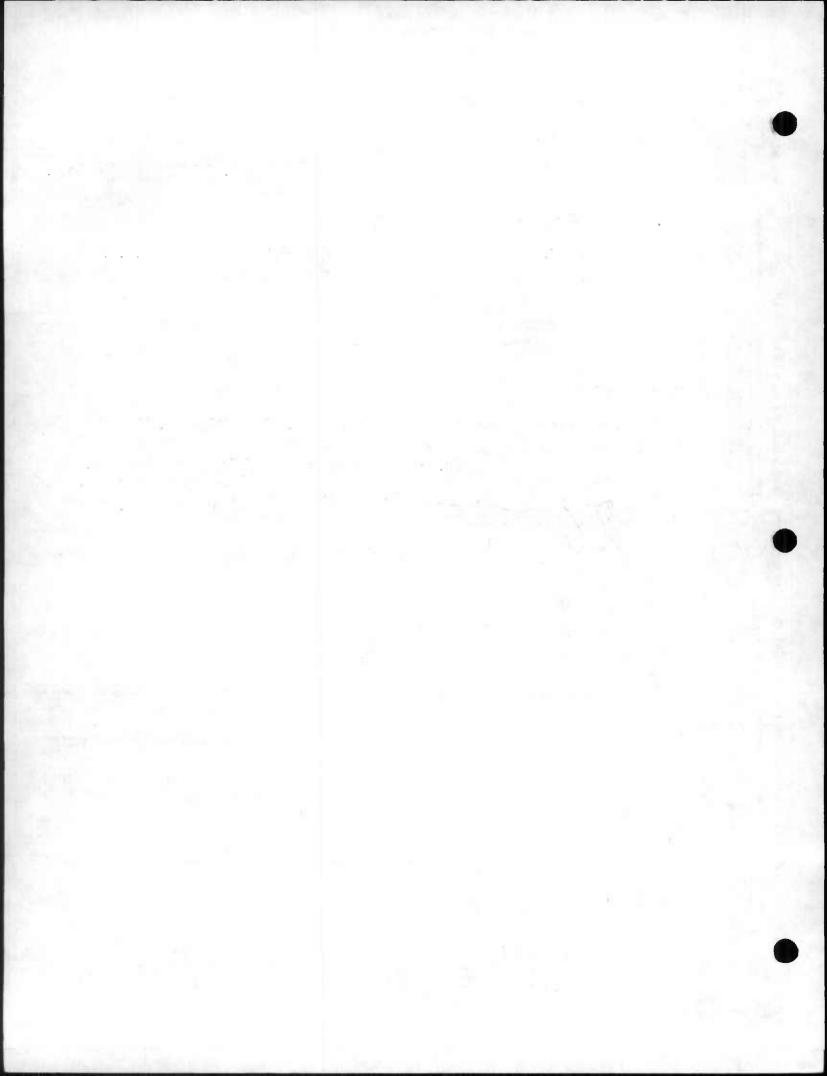
GBINC C

30. Name and address of person who completed cause of death (item 23a) (Type, Print)



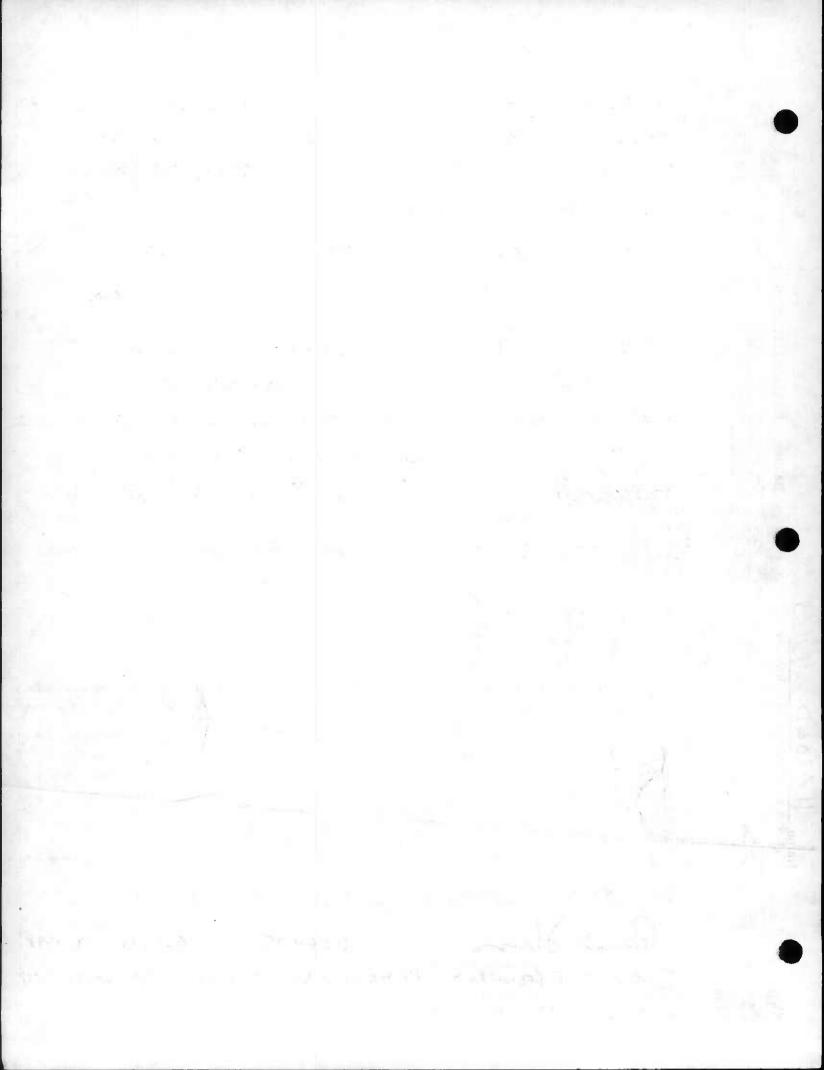
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			C	ertifica	te of	Death	R	eg. No. 9 8	2	7163
Ob i . i	1. Decedent's Name (First, Middle, Las						2. Date of Dea Month		Vear	3. Time of Death
Physician /Medical	Joseph Edwa	rd Pcolka	ì				August	31, 1	998	11:45 P
Examiner	4a Facility Name (If not institution, give						or Location of Death	4c. County		
N	Cherrywood Nursi	0				Reister			timor	e
Funeral Director	047-07-1104	7. Age (In y	s. last birthda 83 Yrs.	Months	Days	Hours N	fin. 8. Date of Birth (Month, Day Aug. 5,	1915	9. Birthp Coun	(State or Fore try) Conn.
Du a	Usual Residence of Decedent 10a, State 10b, County	10c.	City, Town or	ocation					1	0d. Inside City Lim
Maryle Bart sho stiffed a	Md. Balti		Pikes							1 □ Yes 2 🔀
effer deeth with the Maryler or items 23s or 28s-f show mither must be notified at / Funeral Director	10e. Street and Number 8115 McDonogh Rd					1208-10	05	0g. Citizen of U	S.A.	try?
0 5 6	11. Marital Status 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1. Yes 2 No K Yes, Give Year or Dates:	U,S. 13	If Yes, spo		lispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or No- lerto Rican, etc.)		ce - Americ ck, White, y: Whi	etc.
1 21215-002 ed within 72 hours ygiena. er than "natural", ft. Completed by	15. Decedent's Ed		16a. Dec	edent's Usi	al Occup	nation during most of	working	16b. Kind of B	usiness/Inc	dustry
within 7	(Specify only highest gra	College (1-4or 5+)	life	DO NOT	ise retire	d)	HORING			
d 212 flied with Hygiene. ther then ont, the	8			С	lerk			Ba	nking	
Viand 2 Vid be filed Mentel Hygi- rked other tite event, To Be Cc	17. Father's Neme (First, Middle, Last)					18. Mother's I	Name (First, Middle,	Maiden Sumar	ne)	
Maryland d2 should be flic h end Mentel Hy 7 la marked oth traumate event	Stephen Pcolka					Ther	esa Duch			
2 should ond Mer la marke aumate	19a. Informent's Name/Reletionship (1	Type, Print)	19b. Me	iling Addres	s (Street	and Number or	Rural Route Number	r, City or Town	Stete, Zip	Code)
2 2 2 2	Marilyn Susan Bar	tram-Daughter	811	5 McD	onog)	h Rd., P	ikesville,	Md. 2	1208-	1005
of Heal	20a. Method of Disposition		. Plece of Dis	position (Na	me of other ple	ce)	Date	20c. Location	- City or To	wn, Stete
	1 Burial 2 Cremetion 3 4 Donation 5 Other (Specify	Removel from State	John	'c Co	mo to	100	9/4/98	Stratfo	rd C	h
Dealtill Page Department Important: Important: Input of any Injury of anger	21. Signature of Funeral Sarvice Licen	see O	JOH	22. Neme e	nd Addre	ss of Fecility	11824 Re			
Depa de la la la la la la la la la la la la la	1 18V 11	().	F	line	Fime	ral Hom				Iu.
_	23a. Part1. Enter the Sistease, of companion, or heary laylure. Ust enty	plications that caused the de						stown,	Md. 2	Approximete
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	. Cerel	ral u	ifan	1.0		tiple, re		f	Onset end Death
<u> </u>		DNO.	(or as a cons	equence or					1	
and and laborated		b. Punto	for me a cons	equence of	_				- +-	
EX EX	if any, leading to immediate	Idilli	Vinc	V Kan					1	
5 E E B	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c. 149/20	ums	WY	*					
. 4 6 5	resulting in death) Last	Deal	clts	Mhi	2					
et the deeth cert dby the attending etached for use. Physician/M		d		1						10
S de de	Part fl. Other significant conditions co	ontributing to death but not r	esulting in the	underlying	cause giv	ven in Pert I.	23b. Did to	obacco une co	entribute to	the cause of dea
se that the de light of the de detached by Physic							101	es 200 No	3 Prol	bebly 4 Unkn
sw requires been a 2 should pleted							24a. Wes e perfor	n autopsy med?	ev co	ere autopsy finding eilable prior to mpletion of cause death?
	E E						104	es 20 No	10	Yes 2 No
sician: The certificata irector, per	25. Was case referred to medical					26. Place of	Death (Check only or	ne)		
3 05 0	examiner? 1 Yes 2 No	Hospitel: 1 Inpatient 2	☐ ER/Outpati	ent 3 D	OA Ott	nor .	a Home 5 Pesid		her (Specif	y)
Phy Phy I	27. Manger of Death	28a. Date of Injury	28b. Time	of	28c. Inju		28d. Describe h			,,
Affer fune	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	м		rk? Yes 2∐No				
tal or Attending P re after death. al Director: After ied in by the funer. Certification:	3 Suicide 6 Could not be determined			street, fecto	ry, office		28f. Location (S City or Tow	treet end Num. n, Stete)	ber or Rure	Route Number,
he Hospital or Jin 24 hours after he Funeral Dire pletely filled in be edical Certil	(Check only 2 Medical Exam	ysician: To the best of my k liner: On the basis of exami	nowledge, de netion end/or	ath occurred	f et the tir n, in my c	me, date and pl	ace, end due to the c ccurred at the time, o	ause(s) end m late end place,	anner es s	tated. the ceuse(s)
within 2 To the P complet	one)	and manner steted.			la Lia	a aucha-		Od Data size:	od /84aash	Day Vand
To the comple	29b. Signature and title of certifier	tala h		1	C. Licens	se number	2	9d. Date signe	1 month,	uay, rear)
	/ /www//	nny		L	101	013		7-1-	78	
20	30 Name and address of person who o	completed cause of death (III	em 23a) (Typ	e, Print)	17	77 Re	istaston	n Rd	2	1208
State Registrar	31. Date filed (Month-Day, Year)-	32. Registrar's Sig	nature	Lac						



State of Maryland / Department of Health and Mental Hygiene

					C	ertifica	ate of	Death		Reg. No.	3 2716	54
Physician		1. Decedant's Name (First, Middla, La	st)						2. Data of De Month	eath Day		of Death
/Medica		William Harold	Riggs						AUGUST	19	1998 8:	C5 A1
Examine	-	4a. Facility Nama (If not institution, giv		r)				4b. City, Town,	or Location of Daal	h 4c. County	of Death	
		Charlestown Car	e Center					Catons		Ba:	ltimore	
Funeral Director		5. Social Sacurity Number 6. S 221-05-9496 1	ax 7. A	nga (In yrs. la 93	est birthd Yrs	Month	dar 1 Yaar s Days		in. DEC 9	nth ay, Yaar) , 1904	9. Birthplaca (Stata Country) Delaware	or Foraign
t show	20	10a. Stata 10b. County Md. Balti	more	-		Location)				10d. Insida (City Limits
ms 23a or 28a-f show	Direct	10e. Street and Numbar 717 Maiden Choi	00 1000	#425			Zip Coda			10g. Citizan of		
al all a	by runera	11. Marital Status 1 Navar Marriad 2 Married 3 Widowad 4 Divorced	12. Was Dacedan Armad Forcas 1 Yas 2 X If Yas, Giva Yaar or Datas	t Evar in U,S ?] No	5. 1	3. Was Dad If Yas, s	cedant of I	dispanlo Origin? an, Maxican, Pu Specify:	(Spacify Yas or No arto Rican, atc.)		ce - Amarican Indian, ck, Whita, atc.	
ygiene. ner then "neture nt, the Westerd	200	15. Daçadant's Ed	lucetion		16a. De	cedent's U	sual Occup	ation		16b. Kind of B	usinass/industry	
" " M	De	(Spacify only highast gra		5+)	(G lift	iva kind of t a. DO NOT	vork dona usa retira	during most of v	vorking			
dien in in in in in in in in in in in in in	5	Elamantary/Secondary (0-12)	Collega (1-4or		1	/. P.	for	T & T A		Teler	phone	
d other	e	17. Fathar's Nama (First, Middle, Last)						18. Mothar's N	lama (First, Middle	, Maiden Suman	na)	
Ment arkad arice	0	Lester Riggs						Abb	oie Viola	Todd		
e me		19a. Informent's Name/Relationship (Typa, Print)		19b. M	ailing Addra	ss (Straat	and Number or	Rural Routa Numb	er, City or Town,	, State, Zip Code)	
alth 27 l		Alice Riggs - w	ife		717	Maide	n Cl	noice Lr	1 #425.	Catons	ville, Md.	2122
Department of Health and Mentel Hygiene. Important if flem 27 is marked other than "natural, important if flem 27 is marked other than "natural, and in jury or other traumatic event, the Medical Examples. To Be Completed by		20a. Mathod of Disposition 1 Burlal 2X Cramation 3 4 Donation 5 Other (Specification)	Ramoval from State	1	natary, o	sposition (A ramatory o	lama of r othar pla	ca)	Data 8/04/	20c. Location	- City or Town, State	
out of the	H	21. Signatural Funguación Den		Balt	TIMOT		0	ton Crm.	- 2-7 98	Laure	I, Ma.	
Department Important any injury Office.		Harris Color	999		9	Sary L	and Addra Kai lashii	ss of Facility Ufman Funation Bl	neral Ho Lvd Elk	me @ Mea	adowridge Md. 21075	MP
nysician	4	276. Harv. Entyche disaasa, or com anock, or haart failura. List only	olications that causa ona causa on aach	d tha daath. lina.	Do not	antar tha m	oda of dyi	ng, such as card	iac or raspiratory a	rrast,	Approxima Interval Ba Onset and	ata atween
/Medical Examiner		tmmedieta Cause (Final disaasa or condition resulting in daath)	COL	16 EST	IVE	H	EA	RT F	FAILUX	25	We	eks
i i	5	, seeming in Galanty		Dua to (or	as a con	sequence o	f):					
an end unel-transit Examiner		Sequantially list conditions, if eny, laading to immadiata ceusa. Entar Undarlying Cause (Disaasa or Injury that initiated events	D	Dua to (or	as a cons	sequance o	f):					
ate has been signed by the ettending physician end page 2 should be deteched for use as the bunel-transit completed by Physician/Medical Examir		that initiated events rasulting in death) Last	c	Dua to (or a	as a cons	saquance of):					
d by the ettendin eteched for use			u									
the distribution of the di	2	Part II. Other significant conditions of	entributing to daath I	but not rasult	ting in the	undarlying	ceusa giv	an in Part I.	23b. Dld	tobecco use co	ntribute to the cause	of death?
igned by the be deteched by Physi		CHRONIC	LENAL	IN	SVF	FKI	ENC	7	1 🗆	Yes 2 No	3 □ Probably 4 □] Unknowr
page 2 should be det	3								24a. Was	an autopsy rmed?	24b. Wara autopsy available prior completion of of death?	to
cate has page 2									10	Yes 28 No	1 □ Yas 2 🗵	No
certificate rector, pag	3	25. Wes cesa referred to medical axaminar?	Managari						eeth (Check only	one)		
를 를 P	2	1 Yas 2 No	Hospital: 1 ☐ Inpati		R/Outpat			4 Kursing	Homa 5 ☐ Resi	danca 6 □Oth	ar (Specify)	
ath. r: After t se funera ation:		27. Mannar of Daath 1 ⊠Natural 5 ☐ Panding 2 ☐ Accidant Invastigation	28a. Data of Inju (Month, Da	ury ay Year)	8b. Time Injun		28c. Injur Wor 1	yat k? Yas 2∐ No	28d. Describe	how Injury occur	red	
rs effer death. al Director: Affer the fine by the funeral Certification:		3 Suicida 6 Could not be 4 Homicide determinad	28a. Place of in	jury - At hom tc. (Specify)	na, farm,	straat, facto	ory, office		28f. Location (City or To	Straat and Numb wn, Stata)	per or Rural Route Nun	n <i>ber,</i>
within 24 hours efter death. To the Fufferal Director: After completely filled in by the fune completely filled in Completely filled in Completely filled in Completely filled in Completely Complete		29e. Cartifier (Check only one) 1 Cartifying Phy	raician: To the best inar: On the basis of and manner st	of examination	edge, da n and/or	ath occurra Invastigation	d at tha tin	na, data and pla pinion, daath oc	ce, end dua to tha curred at tha tima,	causa(s) and ma data and place,	anner as steted. and due to tha causa(s)
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		> Benow	Hum				D	2647	3	Augu	st 19,	1998
8	3	80. Name and address of person who c	ompleted causa of	death (Item 2	(Typ	e, Print)	DEA	Choi	(E LA	NE, R	ALTIMORE	2127
State Registrar	1	31. Data filed Stepto, Day, Year 998	32 Ragisti	rar's Signatu	ra G.	An	W.	,				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month 516 ROGINSON 4b. City, Town, or Location of Deeth trank 1999 4a. Facility Neme (If not institution, giva straat and number) 4c. County of Death Joseph Richey Hospice N/A Baltimore $\begin{array}{ll} \mbox{If Under 24 Hrs.} & \mbox{8. Dete of Birth} \\ \mbox{Hours} & \mbox{Min.} \\ \mbox{APR} & \mbox{30,} & \mbox{1934} \end{array}$ 5. Social Security Number If Under 1 Year 7. Aga (In yrs. lest birthday) Birthplace (State or Foreign Country) 1 M 2 □ F Days Yrs. 64 215-30-8115 Maryland Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Insida City Limits N/A Baltimore Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1 W. Conway St., Apt. 315 21201 USA 12. Wes Dacedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Never Married 2 Marriad 1 ☐ Yas 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Yes 2 X No Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Spacify only highest grede completed) 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Cotlege (1-4or 5+) Elementary/Secondery (0-12) UNK. UNK. 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Joseph William Robinson, Sr. Lillian Elizabeth Stoney 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Robert H. Robinson/brother 723 207th St. Green Haven, MD 21122 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 □ Burial 2 Cremation 3 □ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Metro Crematory, Inc. 9/1/98 Baltimore, MD 21. Signeture of Funeral Service Licensee Cremation Society of Maryland, Inc. Swal A. She 299 Frederick Rd. Baltimore, MD 21228 Edward A Gregorchik 23a. Part1. Enter the diseases or complications that caused the death. Do not antar the mode of dying, such es cardiac or respiretory errest, shock, or heer feilure. List only one ceuse on each line. Approximete Intervel Between Immediate Cause (Final CARCINOMA LUNG WITH METASMSES OMONTHS diseasa or condition resulting in death) Due to (or es e consequence of): Sequentially list conditions, if eny, leading to Immadiete cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Due to (or es e consequance of): Pert II. Other eignificent conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings aveileble prior to completion of cause of deeth? 24e. Wes en eutopsy parformad? 1 ☐ Yes 2 ☐ No 26. Piece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) TOSPICE 2 No 27. Menne of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work?

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certificete

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After

within 24 hours after death. To the Funeral Director: A

completely filled in by

Hospital or Attanding Physician:

To the

Division of Vital Records, P.O. Box 68760.

Physician

/Medical

Examiner

MD

Funeral Director

Completed by

Be

Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Examinal must be notified at

7 is marked other traumatic event, i

or other t

Department of Important: If any Injury or

Physiclan /Medical

Examiner

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mantal Hygiana.
int: If item 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0020

Examiner Physician/Medical Be Completed by Medical Certification: To

25. Was cese referred to medicel exeminer?

1 ☐ Yes

5 Pending Investigation 1 Natural 2 Accident 6 Could not be determined 3 Sulcida 4 - Homicide

29a. Certifier (Check only one)

1 ☐ Yes 2 ☐ No 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, State) 1 Cortifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Samuel end title of certifier

29c. License number D06933 29d. Data signed (Month, Dey, Year)

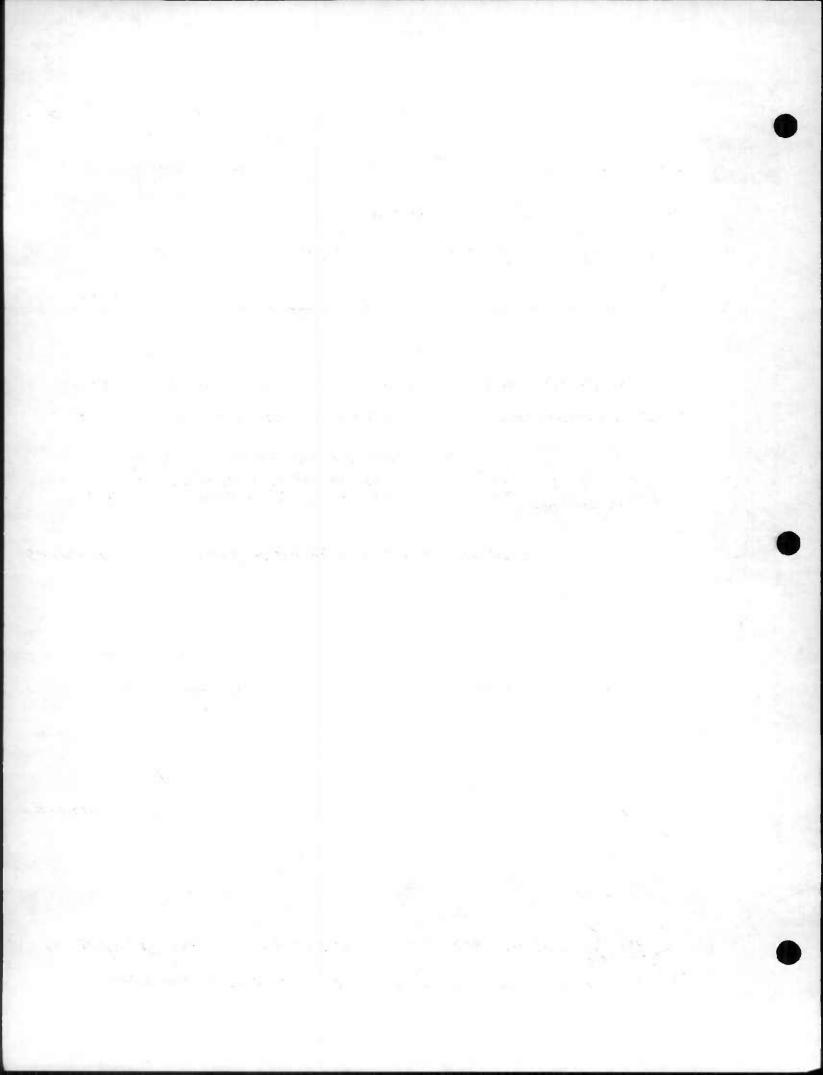
30. Neme and address of person who completed ceuse of death (Item 23e) (Type, Print) GIBBON WW READ SREET

BALTIMORE HD 21201

State Registrar

32. Registrar's Signeture

G. Sparks



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Dey **Physician** Sept. 03, 1998 2:35AM Walter Rowe, Jr /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4e Fecility Neme (If not institution, give street end number) Examiner Greater Baltimore Medical Center Baltimore Baltimore If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Yeer) If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** Deys Months 10 M 20 F Maryland Director 212-03-7626 June 1 1908 90 Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County rithan "natural", or items 23s or 28s-f show the Medical Examiner must be notified at the Maryta 1 ☐ Yes 2 XNo MD Baltimore Catonsville Director 10e Street and Number 10f Zip Code 10g. Citizen of Whet Country? 105 S. Paradise Avenue 21228 USA Funeral 12. Wes Decedent Ever In U,S. Armed Forces?

1 Yes 2 Yo
If Yes, Give 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Raca - American Indian, Bleck, White, etc. Illed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: White Specify: À 3 Widowed 4 □ Divorced Year or Dates: Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Etementery/Secondery (0-12) College (1-4or 5+) Hygiene. 12 n/a Printer Printing ris marked other 18. Mother's Name (First, Middle, Maiden Surneme) 17 Fether's Neme (First Middle Last) Pages 1 and 2 should be till ment of Health and Mental H tant: If item 27 is merked off jury or other traumatic even 89 Howard Walter Rowe, Sr. Helen Jane Shadd 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) V. Jacqueline Fenner/daughter 339 E. Main St., Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other pleca) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) Department of Important: If any injury or Loudon Park Cemetery 9/5/98 | Baltimore, MD 21. Signature o 22 Name and Address of Fecility Lemmon Funeral Home Michael J. Fiagle 10 W. Padonia Rd., Timonium, MD 21093 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Final diseese or condition resulting in deeth) Examiner Examiner Signan and to begat-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequenca of) P.O. Box 68760 Physician/Medicai phys. tha death certificate Due to (or es e consequence of) signed by the e 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by law requires 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? Completed 24a. Wes en eutopsy performed? page 2 s has 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificate director, or Attending Physician: Be 25. Was case referred to medical 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 1 Minpatient 2 ☐ ER/Outpetient 3 ☐ DOA Certification: To this funerel 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1. Neturel 5 Pending investigation 1 ☐ Yes 2 ☐ No deeth. 2 Accident ofter deetl 6 Could not be determined 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 24 hours effer to Funeral Direct pletaly filled in b 4 Homicide 29a. Certifier Eccutifying Physician: To the best of my knowledge, death occurred et the time, dete end pleca, end due to the cause(s) end menner as steted. edicai To the Hosp within 24 hor To the Fune completaly ti 2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier ce Mn 20649 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) John Bowie, M.D. 6800 York Road Towson, MD 21212 Suite B 31. Dete filed (Month, Day, Year) 32. Registrer's Signature Darles

DHMH 16 Rav 6/95

Registrar

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7.1 AND THE STATE OF T ARE THE THE RELEASE

Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Vea **Physician** 3.00 m September 300 Joseph. 1998 /Medical 4e Fecility Neme (If net institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth **Examiner** Franklin Woods Nursing Home Baltimore Rossville If Under 1 Year If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. lesf birthday) Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Dev. Year) **Funeral** 1 M 2□ F Months Deys Yrs. Director 216-14-8388 Oct. 8,1923 Maryland Usuei Residence of Decedent 10d. Inside City Limits the Meryland 10a, Stete 10h Count 10c. City. Town or Location 7 is marked other than "natural", or items 23s or 28s-f show treumstic event, the Moulcal Exactions must be notified as 1 ☐ Yes 2 No Eastpoint-Baltimore Md. Baltimore Director 10f. Zip Code 10e. Street and Number 10g. Citizen of Whet Country? 21224 U.S.A. 7143 Eastbrook Avenue Funerai death 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 □ No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Merital Status Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0020 1 ☐ Yes 2 TNo Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within 1 and of Health and Mentel Hygiene.
mt: If item 27 is marked other than "nry or other treumatic event, its Met Elementary/Secondary (0-12) College (1-4or 5+) 8 (Truck) Mechanic Transportation-Trucking 18 Mother's Neme (First Middle Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Josephine Glorioso Joseph Russo 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Joseph Russo / Son 2213 Lodge Farm Rd., Baltimore, Md. 21219 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removel from State permit. Page Department of Important: If any Injury or once. Gardens of Faith Cemetery 9-8-1998 Rossville, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecilit 21. Signature of Funerel Service Licensee Moran-Ashton-Dabrowski Funeral Home, Inc. The. 3000 E. Baltimore St., Baltimore, Md. 21224 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest shock, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset end Deeth Physician /Medical Immediate Cause (Final disease or conditi-resulting in death) Examiner Examiner Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Disease or Injury that initiated events resulting in death) Lest Due to (or es a consequence of) Hypertension Box 68760. Physician/Medical Que to (or es e consequence of) USe Pert II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown ascellar Thise are signed t þ 24b. Were eutopsy findings aveilable prior to completion of cause of deeth? 24a. Wes en eutopsy Completed Vascerlas hes 62tes 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical examiner? Be 26. Piece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 Yes 2 No this 28e. Dete of Injury (Month, Dey Year) funeral 27. Manner of Death 28d. Describe how Injury occurred 28b Time of 28c. Injury et Work? After or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after deat Director: 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a Hospital TSI Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the ceuse(s) end manner as stated.

2 Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) end menner stated. 29a. Certifier Medicai within 24 hor To the Fune completely fi (Check only one) \$ 29c. License number 29d. Date signed (Month, Dev. Year) 29b. Signeture en al cortifie 0 28 ptmber 34 1998

Franklin

Square Drive #312. Balkinose

Registrar

30. Name end address of person who completed ceuse of deeth (item 23e) (Type, Print)

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State of Maryland / Department of Health and Mental Hygiene

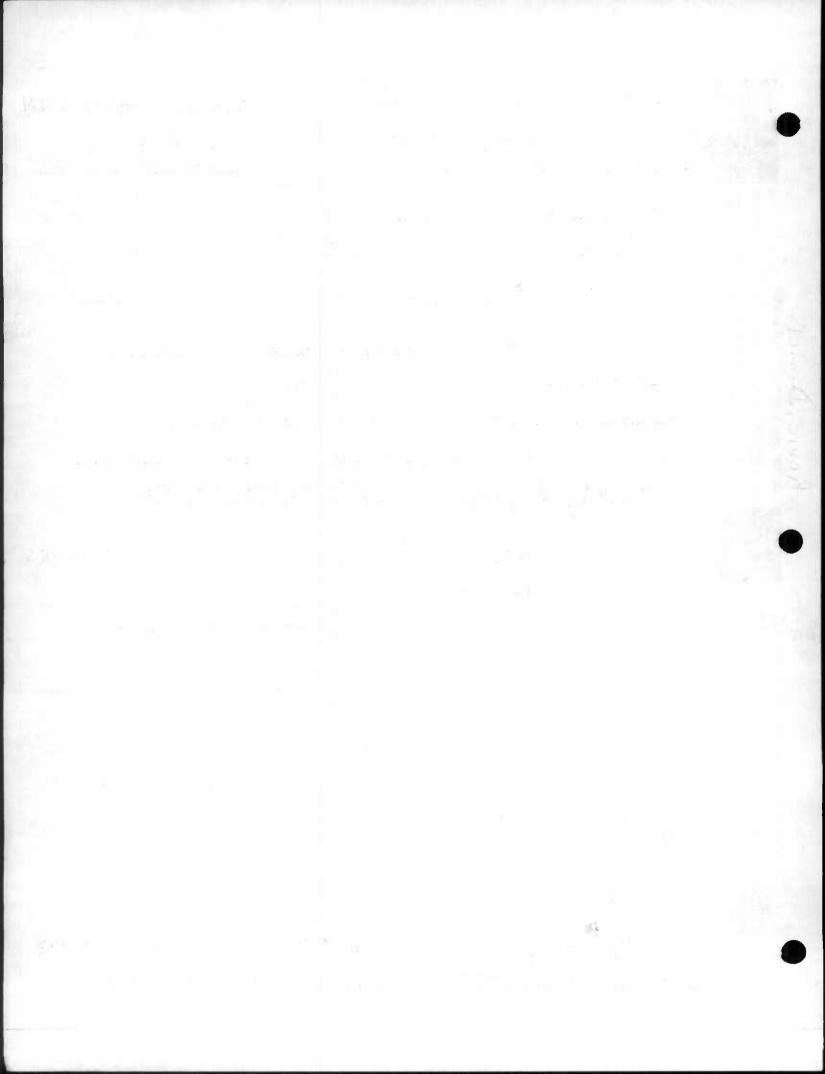
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death September 2, 1998 11:10 A.M **Physician** Daniel Raymond Revie, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Center

Hunder 1 Year

Days Rosedale Balt Hours Min. March Day Year 1929 Franklin Square Nospital Baltimore 5. Social Security Number 9. Birthplece (State or Foreign Country) Pennsylvania Age (In yrs. last birthday) **Funeral** 723-18-3903 1 M 2 □ F Months Days 69 Yrs. Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Mooical Examiner must be notified at Baltimore Director Baltimore 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20 Cedar Dr. 21220 USA Funeral 12. Was Decedant Ever in U,S. Armed Forces? 1 (2X/es 2 □ No If Yes, Give Year or Dates: Kore Was Decedant of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritel Status Pages 1 end 2 should be filed within 72 hours effer onent of Health and Manial Hygiene. Int: If ftem 27 is marked other than "natural", or iten 1 Never Merried 2 Married 1 ☐ Yes 2 2 No Specify: ρ Korean Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade com. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electrical Engineer Beth. Steel 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maidan Surname) Be Daniel Revie, Sr. Matilda Rea 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Shirley Revie/ Wife 20 Cedar Rd. Baltimore, MD. 21220 other 20a. Method of Disposition 20b. Placa of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burlal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Depertment of Important: If any Injury or Injury or Shoop's Cemetery 9-9-98 Harrisburg, PA. 21. Signature of Funerel Service Licenses 22. Name and Address of Fecllity Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, MD. 21204 23a. Part1. Enter the disease, d'comblications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate rval Bet **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Sepsis 12 HOURS Examiner Due to (or as a consequenca of) Examiner neumonilis or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the ettending physician and and Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last oid Thenapy For Bronchiolitis obliterans
Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Teroid Physician/Medicai Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ρ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yas 2□ No funeral director, 25. Was casa raferred to medical axaminer? Be 26. Placa of Daath (Check only ona) 1 Yes 2 No Othar: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, straat, factory, offica building, etc. (Specify) filled in by 4 Homicide 24 hours a Funeral C 29a. Certifier (Check only one) 1xt Certifying Phyalcien: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. Medicai To the Hosp within 24 hor To the Fune completely fi 29b. Signatura and title of cartifier 29d. Date signed (Month, Day, Year) 20907 30. Name and addrass of parson who completed cause of daath (Itam 23a) (Type, Print) 10 Dr Marie Chatham 9000 Franklin Square Drive Baltimore, Maryland 21237 31. Date filed (Month, Day, Year) 32. Ragistrar's Signatura State 4 1998 Registrar **DHMH 16 Rev 6/95**



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death **Physician** Month Suella Fite Ranck /Medical 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Washington County Hospital Hagerstown
| If Under 24 Hrs. | 8. Da (M.) Washington If Under 1 Year 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country)
 PA **Funeral** 1 M 2 XF Days Yrs 91 Director 263-50-2538 Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or items 23a or 28a-f show Examiner must be notified at 1XYes 2 No Director MD Washington Williamsport 10e. Street and Number 10f. Zip Code 10a. Citizen of Whet Country? Funeral 16505 Virginia Avenue 21795 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 (XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 □ Never Married 2 □ Married þ 1 ☐ Yes 2 No Specify: Specify: 3 X Widowed 4 □ Divorced White Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Registered Nurse Medical Care other Maryland permit. Pages 1 end 2 should be file Depertment of Haath and Mental Hy, Important: if them 27 is marked othe any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be E. Ross Fite Elizabeth Yeakle 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosalie Miller/Cousin 493 Ridgeway Avenue Statesville, NC 28677 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete Date 1X Burial 2 Cremetion 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Rehobeth U.M. Cemetery 8/29/98 Mercersburg, PA 21. Signature of Fanerai Service License 22. Name end Address of Facility Grove Funeral Home, P.A. 141 West Main Street Hancock, MD 21750-0368 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart feilure. List only one cause or each line. Approximate Interval Between Onset and Deeth **Physician** Immediate Ceuse (Final diseese or condition resulting in death) Cardio respirator /Medical Examiner Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Last Cordio Vascular Diceges LOUTS Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 □ Probably 4 Unknown yd bengis Septicemia, seizure discorders 1 Tyes 2 No by Division of Vital Records, should be Pardiac Arrythmia Diabetis Mellitus 24b. Were eutopsy findings eveilable prior to completion of cause of death? Completed 24a. Wes an autopsy performed? DVarian Cy certificate 1 ☐ Yes 2 ☐ No Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Napatient 2 ER/Outpatient 3 DOA 1 Yes No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this 27. Menner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how Injury occurred 5 Pending investigation 2 Ascident 1 ☐ Yes 2 ☐ No or Attend eftar deeth Diractor: / To the Hospital or Atter within 24 hours efter dee To the Funeral Director completely filled in by th 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier xaminer: On the besis of examination and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29b. Signature and title of ce 29d. Date signed (Month, Day, Year) son who completed cause of death (Item 23a) (Type, Print) jeet. Haperstown MI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 98 Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Deeth 3. Time of Deeth Month **Physician** CHWALBE CHARD EPTEMBERI 1998 /Medical 4c. County of Deeth Facility Name (If not institution, giva straet end number) City, Town, or Location of Deeth Examiner STEMS BALTIMORE
If Under 1 Year If Under 24 Hrs MARYLAND MEDICAL NIVERSITY OF 6 Sex Sociel Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Months Deys Yrs 126-38-1899 48 Director 1949 New York Usual Residence of Decedant with the Maryland 10a Stete 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner nast be notified at Md. Director Howard Columbia 1 ☐ Yes 2 ☐No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 6 9434 Old Man Court 21045 **USA** items 23a Funeral 11. Merital Status 12. Wes Decedent Ever in U,S. Armed Forces? Was Dacadent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, Whita, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygione. Important: If Item 27 is marked other then "natural", or item any injury or other traumatic event, the Modest Exercise. 1 Never Married 2 M Married 1 ☐ Yas 2 ☒ No If Yes, Give Yaar or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: þ 3 ☐ Widowed 4 ☐ Divorcad Specify white Completed 15. Decedent's Education (Specify only highast grede completed) 16a. Decadent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Director of Microbiology Medical 17. Fether's Name (First, Middle Last) 18. Mother's Name (First, Middla, Maiden Surneme) Be Julian H. Schwalbe Nancy Thampkin 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Schwalbe - wife 9434 Old Man Court, Columbia, Md. 20b. Placa of Disposition (Neme of cemetery, cremetery or othar place) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremation 3 ☐ Ramoval from State 4 ☐ Donetion 5 ☐ Other (Specify) 9/03/98 Meadowridge Memorial Park Elkridge, Md. 21. Signature of Funeral Service License 22. Neme end Addrass of Facility Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 7250 Washington Blvd., Elkridge, Md. 21075 23e. Pert1. Ept a the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or learn failure. List only one cause on each line. Approximate Intervel Between Onset end Death Physician Immediate Ceuse (Finel disease or condition resulting in death) /Medical 2 MONTHS DENOCARCINOMA **Examiner** Due to (or es e consequenca of): Examiner physician and the burial-transit that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events rasulting in deeth) Lest Due to (or es e consequence of): P.O. Box 68760. Physician/Medical Due to (or as a consequenca of): signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. þ or Attanding Physician: The law requires 24b. Were eutopsy tindings eveileble prior to completion of cause of deeth? Completed 24e. Wes an eutopsy performed? 2 No certificate 1 Yes 1 ☐ Yes 2 No Be 25. Wes case referred to medical exeminer? 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To Minpatient 2 ☐ ER/Outpetient 3 ☐ DOA this 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? 28e. Date of Injury (Month, Dey Yeer) After 5 Pending Invastigation 1 Neture 1 □ Yes 2 □ No hours after death. 2 Accident Could not be determined 3 Suicide 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) à 4 Homicide 24 hours a Certifying Phyeician: To the best of my knowledge, death occurred et the time, date end piece, end due to the ceuse(s) end menner as steted.

2 Medical Examiner: On the basis of exeminetion end/or invastigation, in my opinion, death occurred et the time, date end placa, end due to the ceuse(s) end manner steted. 29e. Certifier (Check only one) 29b. Signeture end title of certifian 29d. Date signed (Month, Dey, Year)

State Registrar

SEP 0 4 1998

Herold & Standiford

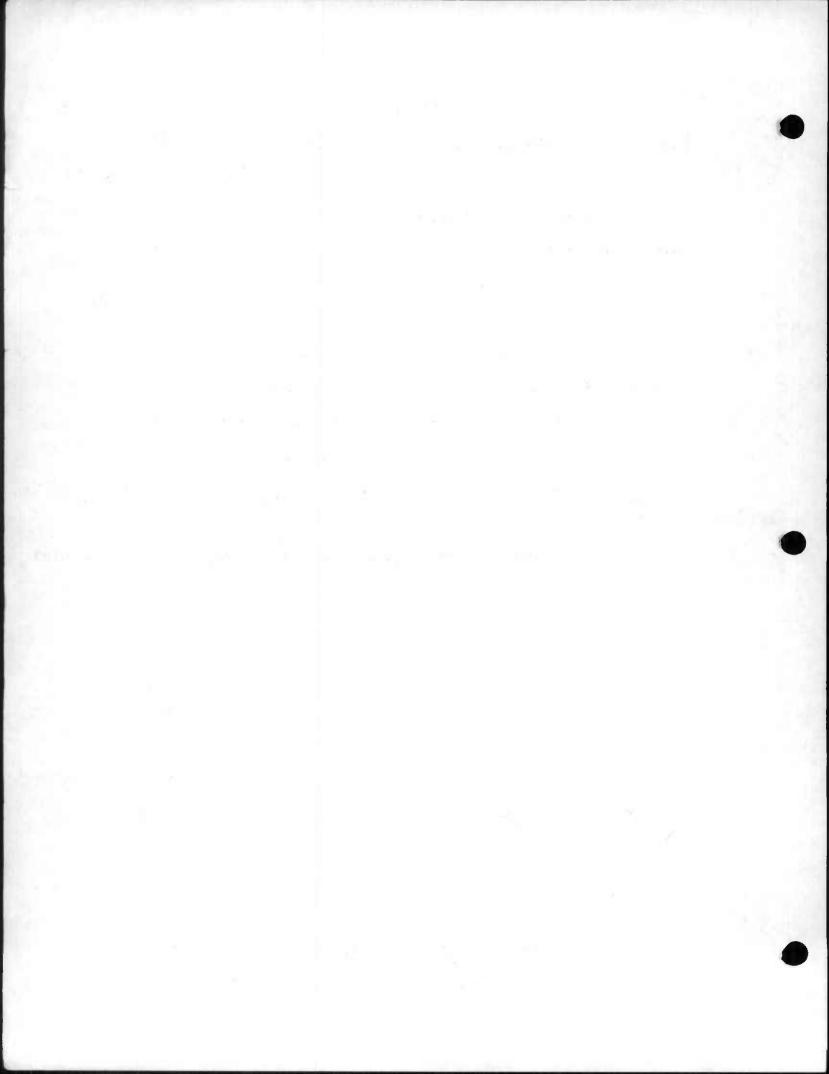
30. Neme end eddress of person who completed cause of death (flem 23a) (Type, Print)

A 22 SOUTH
32. Registrar's Signature
A

Sports

GREENE STREET BALTIMORE MÃI

MARYLAND

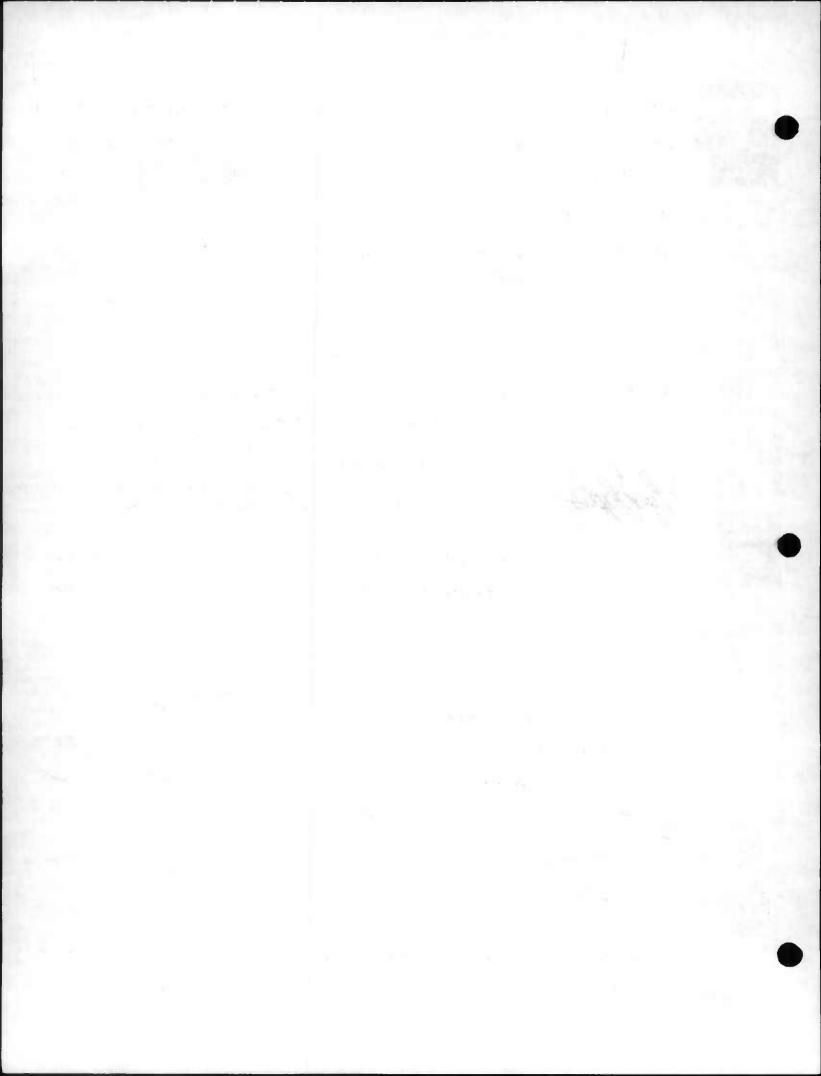


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death **Physician** Month Vincent Sparta August 17, 1998 8:55 PM /Medical 4a. Facility Nama (If not institution, give streat end numbar) 4b. City, Town, or Location of Death 4c. County of Death Examiner Laurel Regional Hospital Laurel Prince George 8. Date of Birth (Month, Day, Year) 5. Social Sacurity Number If Under 1 Year If Under 24 Hrs. 7. Aga (In yrs. last birthday) Birthplace (Steta or Foraign Country) **Funeral** 1 Q M 2 □ F Days Hours Yrs Director 212-37-5780 JULY 23, 1992 Maryland Usuat Rasidance of Dacedani 10a State 10c. City. Town or Location 10d. insida City Limits permit. Pagas 1 and 2 should be filed within 72 hours aftar death with tha Maryla Department of Haelth and Mental Hygiana. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified an any Md. Howard Jessup 1 Yas 2 XNo Director 10e. Street and Number 10f. Zip Coda 10g, Citizan of What Country? 8205 Washington Blvd., Lot #10 20794 USA Funeral 12. Was Dacadant Evar in U,S. Armed Forcas? 1 ☐ Yes 2 ሺ No If Yas, Giva Yaar or Datas: Was Dacedant of Hispanic Origin? (Spacify Yas or Notif Yes, specify Cuben, Maxican, Puarto Rican, etc.) 14. Race - Amarican Indian, Black, White, etc. 1 Navar Marriad 2 Married 1 ☐ Yas 2 ☑ No Specify: white þ Spacify: 3 ☐ Widowad 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highast grade complated) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) College (1-4or 5+) Child Child Baltimore, Maryland 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be Vincent M. Sparta, Sr. Jonni R. Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Numbar, City or Town, Stata, Zip Coda) Jonni Jackson - mother 8205 Washington Blvd., Lot #10, Jessup, Md. 20b. Ptaca of Disposition (Nema of cemetery, crematory or other placa) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Data 8/21/98 1 X Burial 2 ☐ Cremation 3 ☐ Ramoval from State 5 Othar (Spacify) Meadowridge Memorial Park Service Licansee 22. Nama and Address of Facility Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc 7250 Washington Blvd., Elkridge, Md. 21075 disaasa, or complications that caused tha daath. Do not anter the mode of dying, such as cardiac or respiretory errest, haart failure. List only ona causa on each line. **Physician** /Medical tmmediata Ceuse (Finet disaasa or condition rasulting in daath) Dehydration 12hrs Examiner Examiner 12 hrs sas truenteritis To the Hospital or Attending Physician: The law requires that the death cartificate be executed within 24 hours after death.

To the Funeral Director: After this cartificate has been signed by the attending physician and complately filled in by the funeral director, page 2 should be deteched for use as the burial-transit Sequentially list conditions, if any, laading to immadiata causa. Enter Underlying Ceusa (Disaasa or injury that initiated events rasulting in deeth) Last Due to (or as a consaquance of) Division of Vital Records, P.O. Box 68760 Physician/Medical Dua to (or as a consequanca of) Part tl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco usa contributa to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown Scizure Disorder þ 24b. Wara autopsy findings eveilebte prior to comptation of causa of daath? Cerebral Palsy 24a. Was an eutopsy performed? Completed Spastic Quadriplegia

25. Was casa raferred to medicat axaminar?

Hospital: __. Be 26. Placa of Death (Check only one) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Rasidance 6 Othar (Spacify) Medical Certification: To 27. Manner of Death 28d. Describe how injury occurred 28b. Tima of 28c. tnjury at Work? 28a. Data of Injury (Month, Day Year) 1 BNetural 5 Panding investigation 1 ☐ Yas 2 ☐ No 2 Accident 3 Suicida 6 Coutd not be datermined Location (Straat and Number or Rural Routa Number, City or Town, State) 28a. Ptace of tnjury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Homicida 1 Certifying Physician: To the bast of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Cartifian 29b. Signature end titla of certifier 29c. Licansa number 29d. Data signed (Month, Day, Yaar) 30. Name and addrass of person who complated capse of deeth (ttem 23e) (Type, Print) September 1, 1998 DRF036 William L. Ray field II MO
sta filed (Month, Day, Year) 32. Racistra's Signature 2 Knoll North Dr. Colombia Ald 21045 31. Data filed (Month, Day, Year) 32. Ragistrar's Signature State Registrar manera



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death Item: 17 per F.H. G-763 9/4/98 reb 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth 2. Dete of Deeth **Physician** 5:45 am September 3, Marguerite Baker Sweany 1998 /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not institution, give street end number) **Examiner** Anne Arundel Futurecare - Chesapeake Healthcare If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** Hours 1 □ M 2 🖸 F Yrs. 216-28-3297 Nov 6, 1907 **Director** Maryland Usuel Residence of Decedent 10e. Stete 10c. City, Town or Location 10d. Inside City Limits ral', or items 23a or 28a-f show Examiner result be normed at 1 ☐ Yes 2 🔀 No Anne Arundel Director Arnold 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 305 College Parkway 21012 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Rece - American Indian, Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Merried 2 ☐ Married 1 Yes 2 No Specify: White à 3 XWidowed 4 □ Divorced "natural" Completed th and Mental Hygiene.
7 is marked other than "natur traumatic event, tre Med call 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any Injury or other traumatic event page. 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Donald I. Sweany ELIJAH COOKMAN BAKER Ada Elizabeth Brown 2 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 8 Brice Road, Annapolis, MD 21401 Donald I. Sweany, Jr./son Sept 7 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Annapolis, MD 1998 Hillcrest Cemetery 22. Name end Address of Fecility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD 21146 auco 23e. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heert failure. List only one ceuse on each line. Approximete Intervel Between Onset end Deeth **Physician** Alute Ryp caroles /refurchers Immediate Ceuse (Final disease or condition resulting in deeth) /Medical Examiner Due to (o es e consequence of) Examiner physician end s the buriel-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or and consequence of): Physician/Medical Due to (or es e consequence of) for use es Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings aveilable prior to completion of cause of deeth? 24e. Wes en eutopsy Completed 1□ Yes 2No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Plece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2 No 2 28e. Dete of Injury (Month, Dey Year) 27. Manner of Deeth Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending 1 Yes 2 No 2 Accident Investigation 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide

vision of Vital Records, P.O. Box 68760,

with the Meryland

filed within 72 hours after death

altimore, Maryland 21215-0020

The law requires that the death certificate be executed signed by the a certificate hes lirector, page 2 s Attending Physician: this death. efter deat Director: A 24 hou. he Funeral Dire ò

To the Hosp within 24 ho To the Fune completely f

State Registrar

Medical

29a. Certifier

(Check only one)

C.V.CYRIAC.M.D 31. Dete filed (Month, Day, Year)

29b. Signeture end title of certifier

Attending Docter

29c. License number D21684

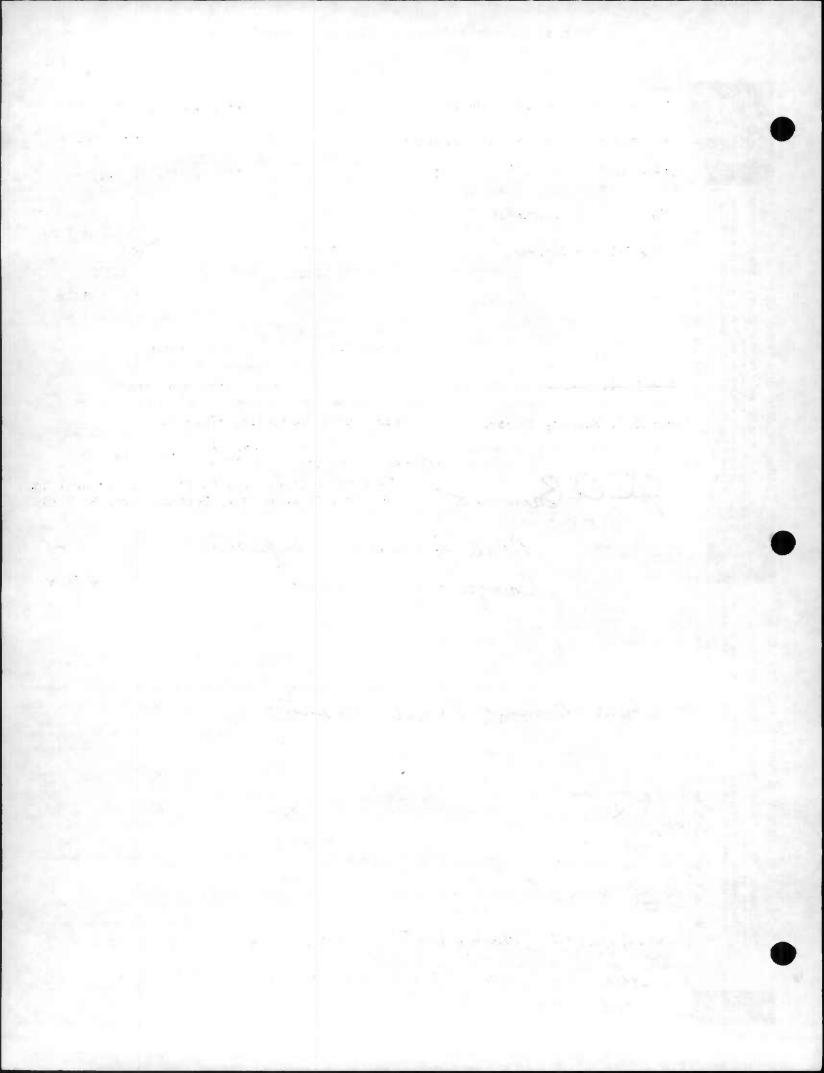
2 Medical Examiner: On the basis of exeminetion end/or investigation, In my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29d. Date signed (Month, Dey, Year)

Whomas M2 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

8109 RITCHIE HWY PASADENA, MO 21122 32. Aegistrar's Signature

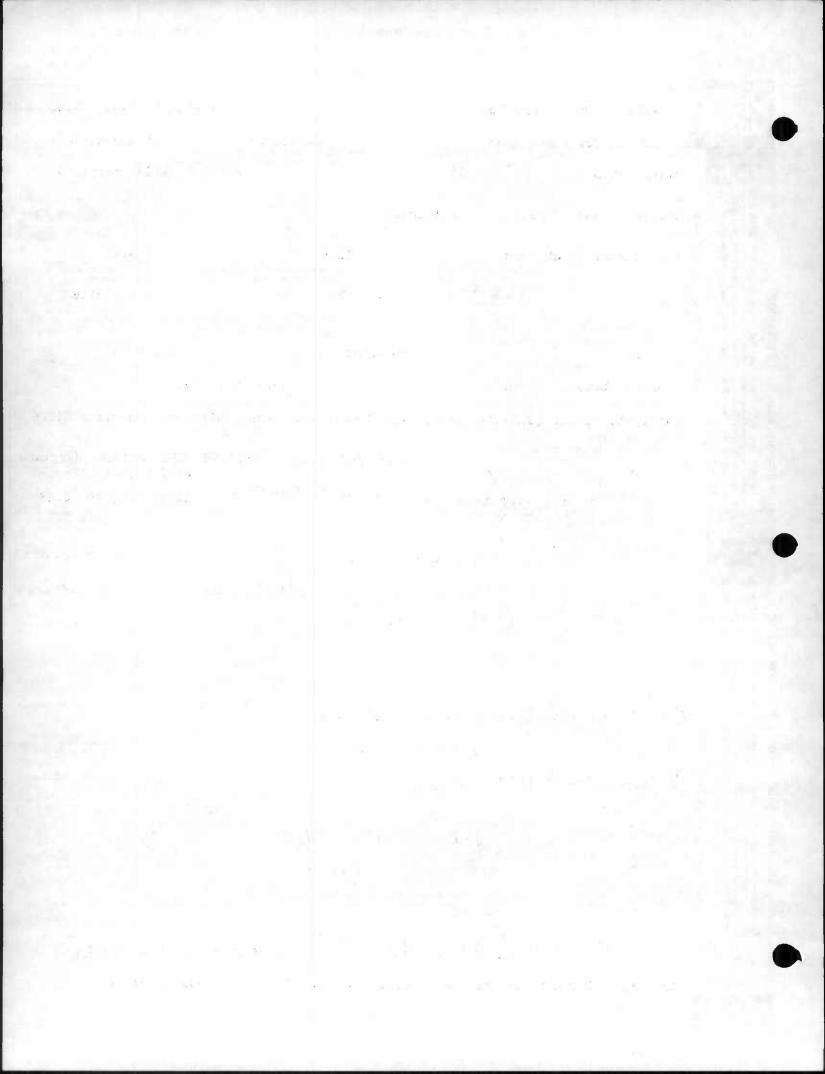
🖄 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Orma SEP 0 4 1998



State of Maryland / Department of Health and Mental Hygiene Q 8 2 7

	1. Decedant's Nama (First, Middla, Last)	2. Data of Death 3. Tima of Death
Physician /Medical	HAZEL REBA STINCHCOMB	Month Day Year SEPTEMBER 1, 1998 8:40 A.1
Examiner	4a Facility Neme (If not institution, give street and number)	4b. City, Town, or Location of Death 4c. County of Death
Funeral	113 Carvel Beach Road 5. Social Sacurity Number 6. Sax 7. Age (In yrs. last birthday) if Undar 1	Baltimore Anne Arundel Co. Yaar if Undar 24 Hrs. B. Date of Birth (Month, Dey, Year) 9. Birthplace (Stata or Foreign Country)
Director	214-20-7983 1 M 2XF 74 Yrs. Morrins Usual Rasidance of Decedant	APRIL 7, 1924 Maryland
M 10 M	10a. Stata 10b. County 10c. City, Town or Location	10d. Insida City Limits
uned uned ctor	Maryland Anne ARundel Co. Baltimore	1 ☐ Yas 24⊠No
be notified Director	10e. Street and Number 10f. Zip 0	
iner must iner must Funeral	113 Out tot Bodon Road	
by E	1 □ Naver Married 2 □ Married 1 □ Yas 2 🕅 No	nt of Hispanic Origin? (Specify Yas or No- y Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Bleck, Whita, etc. Specify: White
t, the Medical Completed	15. Decedant's Education 16a. Decedant's Usual (Specify only highest grade completed) (Give kind of work	Occupation dona during most of working ratified) 16b. Kind of Businass/Industry
mpl mpl	Elamentery/Secondary (0-12) College (1-4or 5+)	ratired) Own Home
	8 Homemaker 17. Fathar's Nama (First, Middla, Last)	18. Mother's Nama (First, Middla, Maidan Surname)
To Be	Harry Edward Bentz	Cora May Tucker
arma arma	19a. informant's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rurel Route Number, City or Town, Stata, Zip Code)
m 27 her tr		el Beach Road Baltimore, Maryland 21226
10	20a. Mathod of Disposition 1 🔀 Buriai 2 🗆 Cramation 3 🗆 Ramoval from Stata	
in in	4 Donation 5 Other (Specify) Glen Haven Men 21. Signatura of Funaral Sarvice Licensee 22. Name end	n. Park 9/4/98 Glen Burnie, Maryland Address of Facility 4107 Wilkens AVenue
eny eny		D FUNERAL HOME Baltimore, MD 21229
	23a. Part / Enter the diseasa, or complications that caused the deeth. Do not entar tha mode shape, or heart failure. List only one cause on each line.	
ician	Ships of heart failure. List only one cause on each line.	Onset end Death
edical miner	Immediate Causa (Final disaase or condition rasulting in death) a.	8 months
	Dua to (or as a consequence of):	l disease 14ear
ial-transit Examiner	Sequentielly list conditions. b. Wellow 150 well Sequentielly list conditions.	e custase 14er
	Sequantielly list conditions, if any, leading to immediata causa. Enter Undarlying Causa (Disaasa or Injury that initiated avants Dua to (or as a consequence of): Dua to (or as a consequence of):	VPas
die the	Causa (Disaasa or injury that initiated avants rasulting in death) Last Dua to (or as a consequence of):	1
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foru	Dad it Other planificant and titles continues to death but not equities in the under time	usa givan in Part I. 23b. Dld tobacco use contribute to the cause of death?
hysi	Part ii. Other eignificant conditions contributing to death but not resulting in the underlying cell of the conditions o	usa givan in Part I. 23b. Did tobacco use contribute to the cause of death?
be del	Chrone ouswelle fulling als	eare
completed by Physician/M	Hypertersin and Segure des	24a. Was an autopsy performed? 24b. Wara eutopsy findings available prior to completion of ceusa of death?
certificate has rector, page 2 b Be Comp	Phones Taid anthrit	1 □ Yas 2 □ No 1 □ Yas 2 ☑ No
Be C	25. Was cesa rafarrad to madicel examinar?	26. Plece of Death (Check only ona)
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	The state of the s	c. Injury a 28d. Describe how injury accurred
In by the lertificat	2 Accident invastigation 3 Suicida 6 Could not be determined to be determined. 28a. Place of Injury - Af home, farm, streef, factory,	office 28f. Location (Streat and Number or Rural Route Number,
filled in by the	4 Homicide determined determined building, atc. (Specify)	City or Town, Stata)
pletaly filled in by the funera edical Certification:	29a. Cartifler (Check only 2 Medical Examinar: On the basis of axamination and/or investigation, i	t tha tima, data and place, and dua to the ceuse(s) end manner as stated. n my opinion, daath occurred at tha time, date and place, and dua to tha ceusa(s)
completely filled	one) end mannar statad.	Licansa number 29d. Data signed (Month, Day, Year)
8	CIA MARIE AND AND AND AND AND AND AND AND AND AND	174591 (+2100)
1	30. Name and address person who completed cause of death (Item 23a) (Type, Print)	1012 10 12 1418
1	7	Glen Burnie, Maryland 21061
State	31. Date filed (Month, Day, Year) 32. Rigistrar's Signatura	hou:



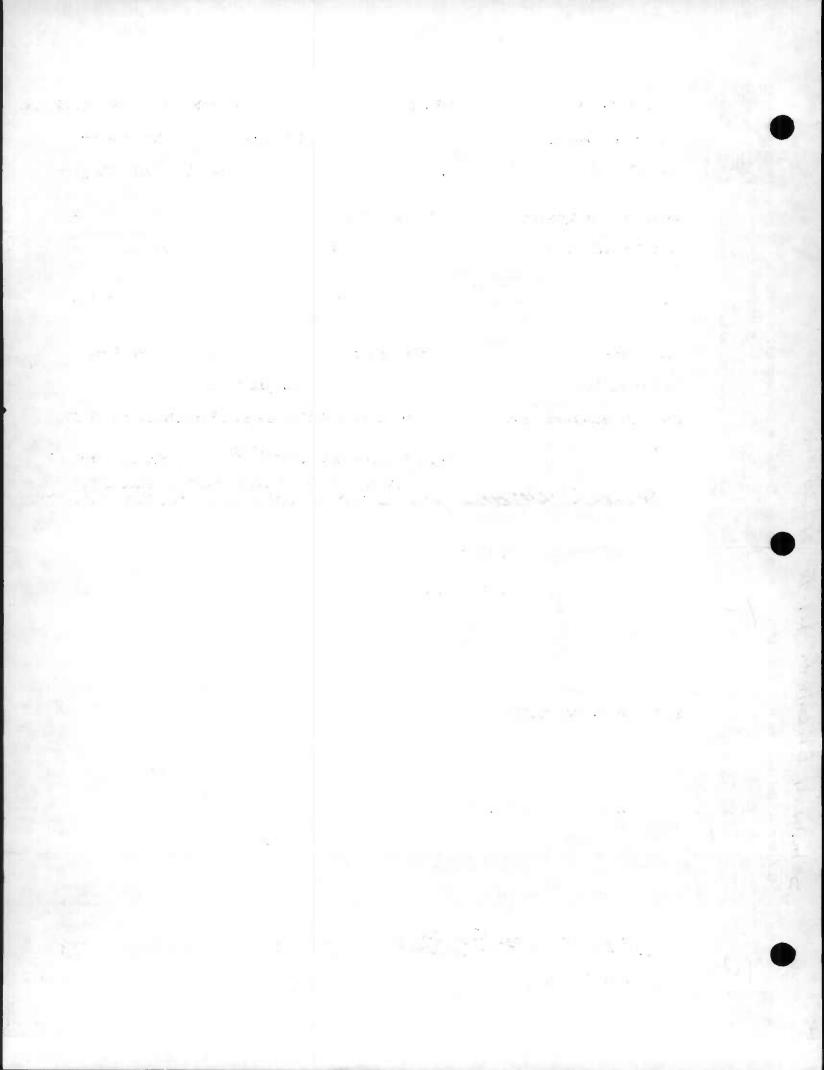
Strai ITEMS		PART I, 27 PER MEO G763			nent of F			Reg. No.	3 27174
	ysician ledical		trait				2. Date of De Month Septem	ber 01.	3. Time of Death 1998 10:51 P.M
Exa Fund Direct		215-46-6520	view Medical C	st birthday) If l	Jnder 1 Year nths Days	Baltimor If Under 24 Hrs. Hours Min.			Birthplace (State or Foreign Country) Maryland
Maryland a-f show	tor	Usuel Residence of Decedent 10a. State 10b. County Maryland Harfor		Town or Location					10d. Inside City Limits 1 ☐ Yes 2X☐ No
23a or 28a-f show	al Director	10e. Street and Number 1916 High Point R			of. Zip Code 2105	60		10g. Citizen of V United	Vhat Country? States
ter des	by Fune	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U,S Armed Forces? 1 [X] Yes 2 □ No If Yes, Give Year or Dates: Vietne		Decedent of F specify Cubi es 2 No	tispanic Origin? (Spe an, Mexican, Puerto Specify:	ecity Yes or No Rican, etc.)	14. Rec Blac Specify	e - American Indian, kk, White, etc. :: White
	rt, the Medical	15. Decedent's Edu (Specify only highest great Elementary/Secondary (0-12)		16a. Decedent's (Give kind life. DO N	Usual Occup of work done OT use retire	during most of worki	ng	16b. Kind of Bu	usiness/Industry
und 2121 be filed within stal Hygiene. d other than	Be Com	12 17. Father's Name (First, Middle, Last)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Repa	irman	18. Mother's Name	(First, Middle,		al Motors
should should mer Mer	To	George Strait 19e. Informent's Name/Reletionship (7)	rpe, Print)	19b. Mailing Ad	dress (Street	Florence on Number or Rura		Albaugh er, City or Town,	Stete, Zip Code)
Fe, 1 and 1 thousand	y or other in	Mrs. Piret Kreek S 20a. Method of Disposition 1 Burial 2 XCremation 3 F 4 Donation 5 Other (Specify)	Removal from State	1916 Hace of Disposition metery, cremator,	(Name of y or other pla		Forest Date /8/98	20c. Location -	MD 21050 City or Town, Stete Maryland
Baltin Permit. P Departme	any injur	21. Signature of Funeral Servica Licans		22. Nar	ne and Addre	ss of Facility Ruck In	с.	, MD 212	
Physic /Medi Exami	ical	23a. Part1. Enter the disease, or complished, or heart failure. List only of limmediate Cause (Final disease or condition resulting in death)	a. DIL	ATED CARD	mode of dyle	ng, such as cardiac o	r respiratory a	rrest,	Approximate Interval Between Onset end Death
ta be executed ysician and	e bunal-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	b	as a consequenc					
0 5	2 2	that initiated events resulting in death) Last	Due to (or a	as e consequenc	e of):				1
hat the o	achec hys	Part II. Other significant conditions con	ntributing to death but not result	iting in the underly	ying cause giv	ven in Pert I.		tobacco usa co Yes 2□ No	ntribute to the cause of death? 3□ Probably 4□ Unknow
S & G	z shou					_		en autopsy emed?	24b. Were autopsy findings eveilable prior to completion of cause of death?
= F #	0 0	25. Was case referred to medical				26. Place of Deatl	1 (Check only o	Yes 2□ No one)	1 Yes 2□ No
Phys of	<u> </u>	examiner? \[\		28b. Time of Injury	28c. Inju			dence 6 Oth	
DIVISION I or Attending after death. Director: After	ed in by the runers Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Placa of Injury - At hom building, etc. (Specify)		actory, office		28f. Location (City or To	Street end Numb wn, State)	er or Rural Route Number,
n Hospital	completely filled in by Medical Certifi		sician: To the best of my knowl ner: On the besis of examination and manner stated.						
To the within 2 To the	W W	29b. Signature and title of certifier	1. King m		29c. Licens	e number			d (Month, Day, Year)
		30. Neme and address of person who co				treet, Bal	ltimore	, Maryla	and 21201

Registrar

ALCOHOLD DE

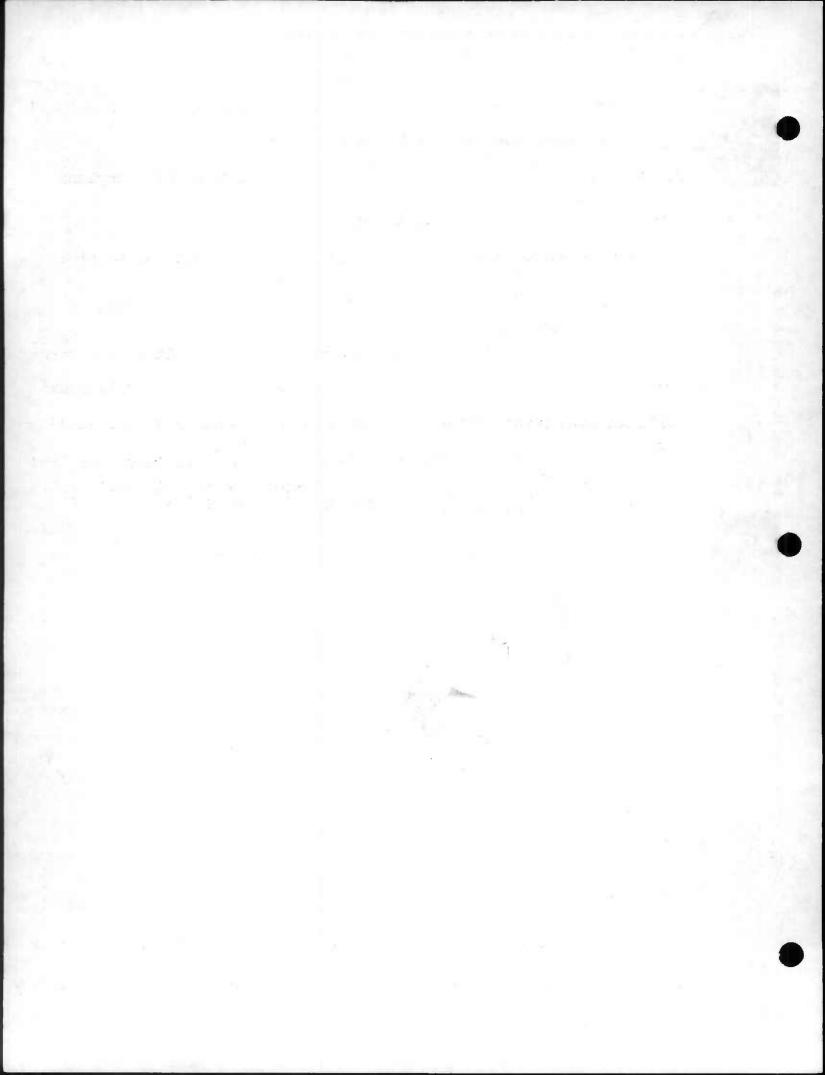
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		1. Decedent's Name	(First, Middle, La	st)			Jorun	icate of	Douti	2. Dete of D	Reg. No.		3. Time	of Death
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	Funeral Director	5. Sociel Security Nur 065-12-88	mber 6. S		7. Age (In y			Under 1 Year onths Days	If Under 24 Hrs	8. Date of Bi		9. Birthp Coun	2	
	and and	Usuel Residence of D	Decedent 10b. County		10c.	City, Town	or Location	on				1	0d. Inside	City Limits
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	ifer death with the Ma r items 23s or 28s-f over marker nothing Funeral Director	10e. Street end Numb						0f. Zip Code 20910			U.S.	Α.		
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15-0	ed within 72 ho ygjene. Nor than "nature It, tre Medical Completed	(Specify	5. Decedent's Ed	ducetion de completed	1)		(Give kind	s Usuel Occup of work done	during most of wo	rking	16b. Kind of B	usiness/Ind	dustry	
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D.	be filed tal Hyg d other event, Be C	17. Fether's Name (F				1101	i Cinare		18. Mother's Na	me (First, Middle	e, Maiden Sumen			
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Man	2 sho ls me ls me raume	19a. Informent's Nam							t end Number or R					
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DC	e inge	4 Homicide	determined	28e. Plec	ce of Injury - A ding, etc. (Spe	t home, far ecify)	m, street,	factory, office			(Street and Num) own, State)	ber or Hure	ai Houte Nu	ım <i>ber</i> ,
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	To the comple comple	29b. Signature and tit	le of certifier		3	0 -		29c. Licen			29d. Date signe	and the same		
		2		2	u			03	9934		SEPT	01/	1998	
	10	30. Name and address	ss of person who	completed car	use of deeth (I	tem 23e) (Type, Print	shads	9934 Gove Ro	#201	Rocha	Me 1	no 2	080
	State Registrar	31. Dete filed (Month,	Day, Yeer)	98 32.	Registrar's Signature	nature	4	1		7				



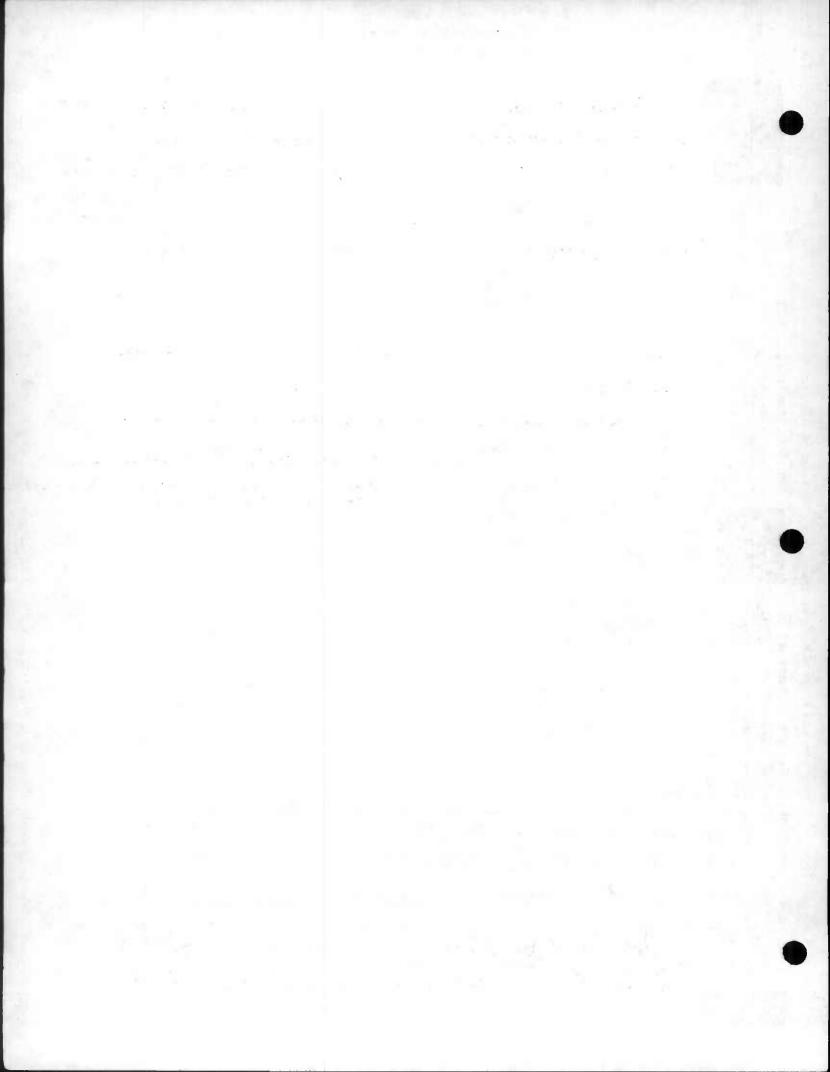
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or 28		10e. Street end Number			1	Of. Zip Code			10g. Citizen of	Whet Cour	ntry?	
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State	3	31. Date filed (Month, Day, Year)	32. Registre	er's Signe	ture de de		(10.		B	ALTI	whit wo are	1



State of Maryland / Department of Health and Mental Hygiene

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Nama (First, Middle, Last) 2. Data of Death Month Day Year AUGUST 30, 1998 06:43 PM GERTRUDE VINCENT 4c. County of Death 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death PRINCE GEORGES CENTER | CHEVERLY PRINCE GEORGES HOSPITAL If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) Days Months 10 M 20 F Hours 579 01 7574 84 Feb. 2,1914 Washington D.C Usual Rasidance of Dacedant 10b. County 10c. City, Town or Location 10a. Stata 10d. Inside City Limits Maryland Anne Arundel Mayo 1 ☐ Yas 2 ☐ No 10e Street and Number 10f. Zio Code 10g. Citizen of What Country? 111 Elliott Place 21106 United States 14. Race - American Indian, Black, Whita, etc. 12. Was Decedant Evar in U.S. Armed Forcas? 1 ☐ Yas X ☑ No If Yas, Giva Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 11. Marital Status 1 Nevar Married 2F3/Married 1 Vas 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry National Elemantary/Secondary (0-12) Cottega (1-4or 5+) Georgraphic 12 Supervisor 18 Mothar's Nama (First Middle Maiden Sumame) 17. Fathar's Nama (First, Middle, Last) William Harper Effie Laurel 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) W. Howard Vincent Husband 111 Elliott Place Mayo Maryland 21106 20b. Place of Disposition (Name of cemetery, crematory or other place) Sept. 3, 1998 20a. Method of Disposition 1 Burial 2 Cramation 3 Ramoval from Stata 20c. Location - City or Town, Stata 4 ☐ Donation 5 ☐ Othar (Specify) Fort Lincoln Cemetery Brentwood Maryland 21. Signature of Funeral Service Licenses 22. Nama and Addrass of Facility Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intervat Between Onset and Death tmmediate Cause (Final MULTIPLE INJURIES disaasa or condition rasulting in daath) Sequentially list conditions, if any, laading to immadiate causa. Enter Undarlying Cause (Disaase or Injury that initiated avants rasulting In death) Last Dua to (or as a consequence ot): Dua to (or as a consequence of): 23h. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 2) No 1 Yea 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 1 ☐ Yas 2 ☐ No 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 27. Mannar of Death 28b. Time of 28c. Injury at Work? 28a. Data of Injury (Month, Day Year) Injury 09:00AM 5 Panding invastigation 1 Natural 08-30-98 1 Yas 2 No OCCUPANT OF VAN VS AUTO COLLISION 2 Accidant 3 ☐ Suicida 6 Could not be 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 I Homicida

physician Box 68760 Physician/Medical \$ P.O. å T of Vital Records. þ Completed Be To Certification: Division

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

72 hours after

permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: if New 27 Ia marked other than "nath any injury or other traumatic event, the Medical DIDG.

Physician /Medical

Examiner

Baltimore, Maryland 21215-0020

Directo

Funeral

à

Completed

Be

25. Was case refarred to medical examinar? 1 Yas 2 No

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

III ELLIOT PLACE, MAYO, MARYLAM

1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner instead.

29b. Signature and titfa of certifier

PMIE

STREET

29d. Data signed (Month, Day, Year)

ted cause of di attr (ttem 28a) (Type, Print) and address of person wh MARIO

300

29c. License number

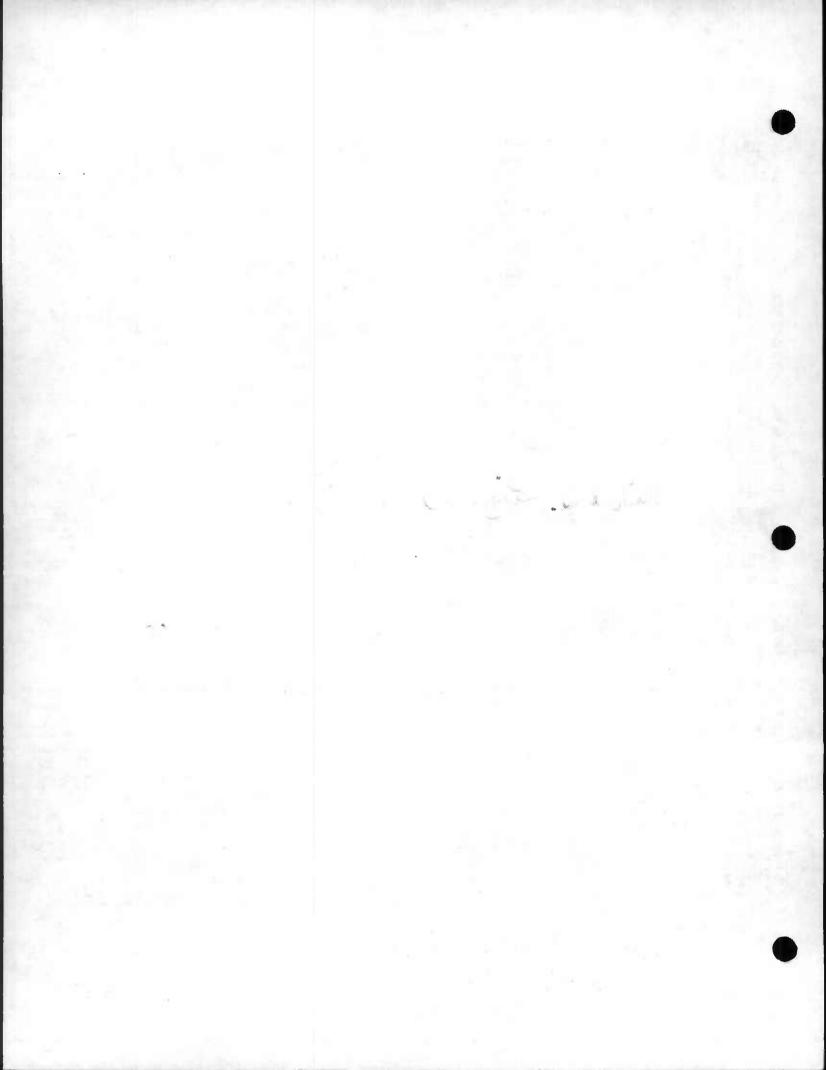
31. Data tiled (Month, Day, Year) SEP 0 4 1991 State 0 4 1998 Registra

29a. Cartifian (Check only

one)

#32. Registrar's Signature

To the To the F



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Yee **Physician** Edward Wesley Watkins 2, 1998 SEPTEMBER 11:26 AM · /Medical 4a Fecility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner St. Agnes Hospital Baltimore N/A If Under 24 Hrs. Hours Min. 5. Sociel Security Number If Under 1 Year 9. Birthplace (State or Foreign 7. Age (In yrs. lest birthday) **Funeral** 1 M 2 F Months Days 216-36-3524 58 1940 Maryland Director Usuel Residence of Deceden 10s State 10c. City, Town or Location 10b County 10d. Inside City Limits Md. Baltimore 1 ☐ Yes 2 ☑ No rns 23a or 28a-f s rmust be notified Lansdowne Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3041 Freeway 21227 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. event, the Medical Examiner 1 X Yes 2 □ No If Yes, Give Yeer or Dates: 1 Never Married 2 Merried ä Maryland 21215-0020 1 Yes 2 No Specify: Specify: white þ 3 ☐ Widowed 4 ☐ Divorced "natural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Pages 1 and 2 should be filed within nent of Health and Menial Hygiene. rnt: if Item 27 is merked other than " iry or other traumetic event, the Mas Elementary/Secondary (0-12) College (1-4or 5+) 12 Chief Inspector Refrig. & Air Condition 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Be Archie Watkins Virgie Mary Everhart 19a. tnformant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Florence Watkins - wife 3041 Freeway, Lansdowne, Md. Baltimore, 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 9/05/98 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Elkridge, Md. Meadowridge Memorial Park 22. Name and Address of Facility Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc 21. Signature of Funeral Service License 7250 Washington Blvd., Elkridge, Md. 23a Partt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, abook, or near failure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** Immediate Cause (Final diseese or condition resulting in death) /Medical met 45+4tic CANLER unknown Examiner Examiner physicien and the buriel-tran Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physiclan/Medical Due to (or as a consequence of): S 980 0 signed by the e 23b. Did tobacco use contribute to the cause of death? Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown p 24b. Were eutopsy findings available prior to completion of ceuse of deeth? 24e. Wes an eutopsy performed? Completed pega 2 20 1 Yes 20 No Be 25. Wes case referred to medical exeminer? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certifications To this 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Dey Year) 28h Time of 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 ☐ Homicide Dire 0 24 hours 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical To the Hosp within 24 hou To the Fune completaly fi 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signeture and title of certifier September 2, 1998 D47353

State Registrar

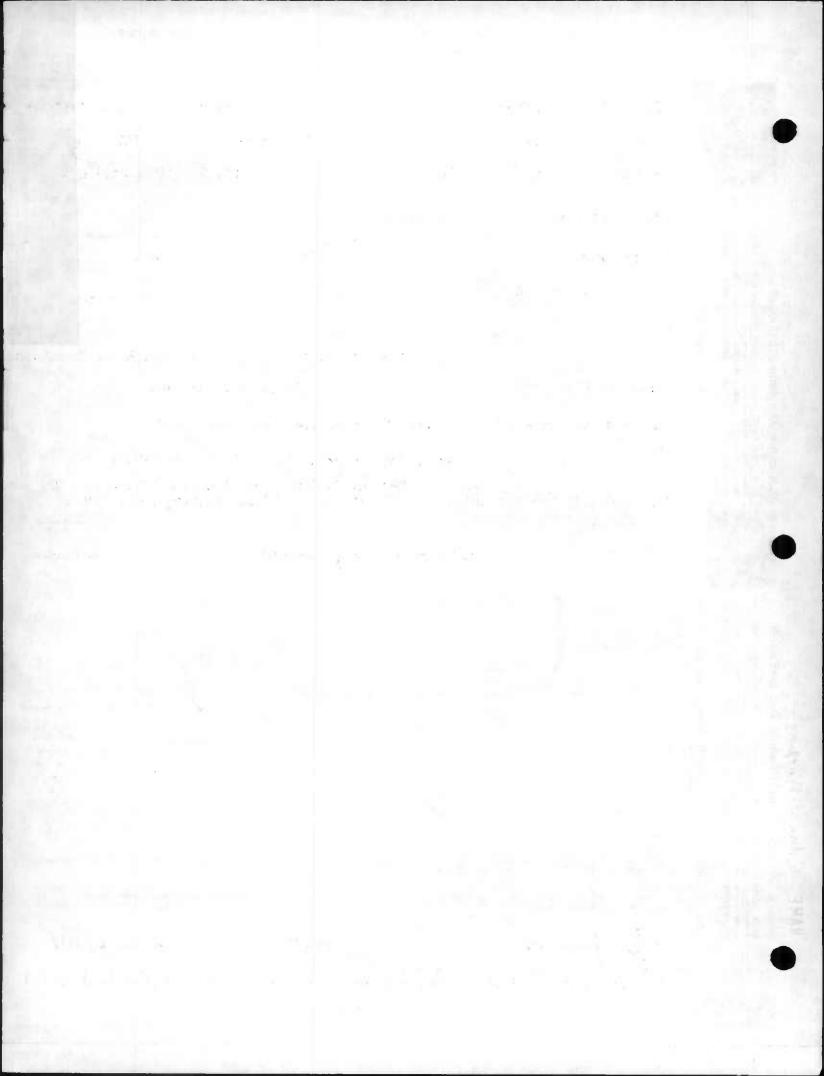
Falck MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

900 Caton Avenue

Baltimore, Maryland 21229

Edward Watking



State of Maryland / Department of Health and Mental Hygiene AUDREY WOMBLE Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Day Year **Physician** AUG. 1998 11:16 AM 28, /Medical 4b. City, Town, or Location of Death 4c. County of Deaph 4a Facility Neme (If not institution, give street end number) Examiner 1928 NORTH FULTON AVENUE BALTIMORE If Under 24 Hrs 8. Date of Birth If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 M 2 X F 36 Maryland Vrs Director unk Usuel Residence of Decedent the Marylend 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ms 23a or 28a-f show must be notified at 1 Nes 2 No Directo more Marvland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 1928 ton dld Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 7 is marked other than "naturel", or items traumatic event, the Medical Examiner ma 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) - American Indien 11. Meritel Status Black White, etc. filed within 72 hours after 1 ☐ Yes 2 No 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Baltimore, Maryland 21215-0020 þ 3 ☐ Widowed 4 ☑ Divorced Yeer or Dates: Hfrican American "naturel", Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life_DO NOT yse retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hyglene. Elementary/Secondary (0-12) Coilege (1-4or 5+) d 18. Mother's Name (First, Middle, Maiden Surneme) 17 Father's Name (First, Middle, Last) Be Peges 1 and 2 should be fament of Health end Mentel I in it item 27 is marked of Vas 2 Ton 191 (Brother) 19b. Mailing Address (Street end Number or Ruse) Route Number, City or Town, State, Zip Code, 19a., Informent's Name/Relationship (Type, Print) on to Shing other t 20b. Place of Disposition (Name of comgrery, crematory or other p 20c. Location - City or Town, State Important: If its any injury or oth 20a. Method of Disposition or other place, 1 X Burlal 2 ☐ Cremation 3 ☐ Removel from State 4 □ Donetion 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facili Ru uneral Joseph Worth Balto. Md. 21216 2772 Ve ther the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cerd or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical OF CIRPHOSIS LIVER Examiner Due to (or as a consequence of): Examiner ettending physician end for use as the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initioted events resulting in death) Last Due to (or as e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): signed by the e 23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were eutopsy findings available prior to completion of ceuse of deeth? Completed 24e. Wes en eutopsy performed? PARTIBL is certificate hes director, pege 2 1 Yes 2 No 10 Yes 2 No Physician: 25. Wes cese referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home XX Residence 6 ☐ Other (Specify) XXYes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 After this 28a. Date of Injury (Month, Day Year) Director: After this 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: or Attending 1 Netural 5 Pending investigation 1 Yes 2 No deeth 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, State) To the Hospital or Atterwithin 24 hours efter dec To the Funeral Director completely filled in by th 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Cartifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es steted.

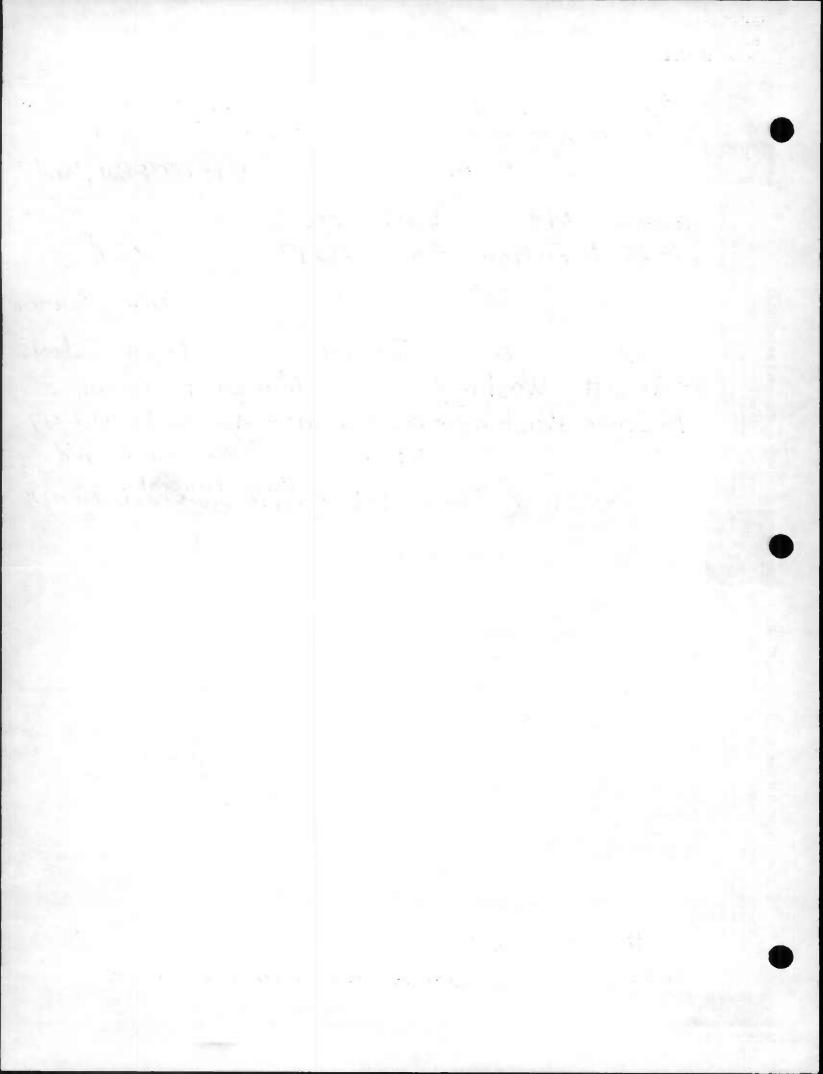
Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a, Certifier edicai (Check only 29d. Date signed (Month, Day, Year) AUG. 29, 1998 29c. License number 29b. Signature and title of certifier O.C.M.E Whente 30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print) KONSTUMM 111 Penn Street, Baltimore, Maryland 21201 BRYDANDS 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 16 Rev 6/95

State

Registrar

SEP 04



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Tima of Death Day Month Year **Physician** Miriam Wilhelm F. SEPTEMBER 3, 1998 9:35 AM /Medical 4a Facility Nama (If not Institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Towson Baltimore If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) Oct. 6, 1914 7. Age (In yrs. last birthday) 9. Birthplace (State or Foraign **Funeral** Months Days 1□ M 2□F Pennsylvania Yrs 214-03-0294-B 83 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show 1 Yes 2 No Maryland Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 급 8810 Walther Blvd. Apt. #1607 21234 U.S.A. death Funeral 12. Was Decedent Evar in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, atc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health end Mental Hygiene. 1 Never Married 2K Married I ☐ Yes 2 ☑ No If Yes, Giva Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: Specify: by 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 12 yrs. 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 27 is marked or traumatic aver 0 Ida Maria Ketterman Harvey W. Frey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health el Important: if item 27 is any injury or other trau 8810 Walther Blvd. #1607 Baltimore, Md. 21234 Frank M. Wilhelm, Jr./Husband 20b. Place of Disposition (Nama of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place 1X Burial 2 ☐ Cramation 3 ☐ Removal from State 9/8/98 Loudon Park Cemetery Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Inc. Towson, Md. 21204 an an And caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. 23a. Part1. Enter the diseasa, or shock, or heart failure. List Approximate Interval Between Onsat and Death **Physician** /Medical Immediata Causa (Final RESPIRATORY FAILURE disease or condition rasulting in death) Examiner Dua to (or as a consequence of): Examiner MULTIPLE ORGAN FAILURE Sequentially list conditions, if any, leading to immediata causa. Enter Underlying Cause (Disaase or injury that initiated events resulting in death) Last Due to (or as a consequence of): thet the death certificate be ex Box 68760. FAILURE RENAL Physician/Medical Due to (or as a consequence of): SEPSIS 980 signed by the at the deteched to 23b. Did tobacco use contributs to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part t. Records, P.O. 2000 3 Probably 4 Unknown 1 Yes þ 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? should Completed complation of cause of death? The lew page 2 s certificate has 1 ☐ Yas 2 No 1 Yes of Vital Physician: 25. Was case referred to medice! axaminer? Be 26. Place of Death (Check only ona) Hospital: number | 1 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No this funeral 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural
2 Accident 5 Pending investigation Division or Attanding 1 ☐ Yas 2 ☐ No 24 hours after death. 6 Could not be datarmined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) filled in by 4 Homicide Hospitai 15 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier completely (Check only within 2. To the F one) the 29d. Data signed (Month, Day, Year) 29b. Signatura and title of certifier 29c. License number D 44728

State Registra

MITCHELL L.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SCHWARTZ,

32. Registrar's Signatura

M.D., 6569 N. CHARLES ST., TOWSON, MD.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🔾 Certificate of Death Reg. No 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 07:47a.m Harry H. Wojtowycz Sept /Medical 4a Facility Name (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Church Home Hospital Baltimore N/A If Under 1 Year M Under 24 Hrs. 6 Date of Birth (Month, Day, Year) 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1∭M 2□F 76 Yrs. Director Ukraine February 5, 1922 057-24-3474 Usue! Residence of Deceden with the Meryland 10a. Stete 10d. Inside City Limits 10b. County 10c. City, Town or Location 7 is marked other than "natural", or flams 23s or 28s-f show treumstic event, the Medical Examiner must be polified at 1 □YYes 2 □ No Director Brook 1 vn N/A Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5600 Ballman Ave. 21225 U.S.A. Funeral death 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Merried 1 ☐ Yes 2 ☑ No If Yes, Give altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: g Specify: te 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) Mechanic American Can Co. permit. Peges 1 and 2 should be flist Depertment of Health and Mentel Hy Important: if item 27 is marked oths eny injury or other treumatic event back. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) 8 Zalopane Tanya Sam Wojtowycz 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 5600 Ballman Ave., Brooklyn, Maryland 21225 Mary Wojtowycz/Wife 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Buriat 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Specify) Baltimore County, Md. St. Michael Ukrainian Cemetery 9/5/98 22. Name and Address of Facility Lilly & Zeiler, Inc. Funeral Home 21. Signeture of Funeral Service Licensee 1901 Eastern Ave., Baltimore, MD 21231 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Death Physician /Medical Immediate Ceuse (Finel disease or condition resulting in death) Examiner Examiner Athero sclerotic physician and the bunal-mansit The lew requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of) Box 68760. Physician/Medical Due to (or as a consequence of): signed by the e Pert It. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? P.O. 1 Yea 2 No 3 Probably 4 Unknown smalek Records, þ 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Was an eutopsy performed? 1 | Yes 2 | 1 | 10 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 8 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 REVOutpatient 3 DOA this 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Atter 5 Pending investigation 1 (9 Neturet To the Hospital or Attending within 24 hours effect death.

To the Funeral Director: Afte completely filled in by the fun 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. edical 29e. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print)

Registrar **DHMH 16 Rev 6/95**

State

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31. Dete filed (Month, Day, Year)

- 901

Spark

E. Fort

32. Registrar's Signature

Baltimore MI)

COMPT

28 JULES 14/10: 27

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth **Physician** 1:45 PM Ethe1 Weitzel ,1998 Sept. /Medical 4a Fecility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7923 Underhill Rd. Rosedale Baltimore If Under 1 Year 7. Age_(In yrs. last birthdey) Birthplece (State or Foreign Country) 5. Social Security Number 213-20-5705 **Funeral** 1□ M 2⊠ F Months Deys Hours Yrs. Director MD Usual Residence of Decedent 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits / is marked other than "natural", or items 23s or 28s-f show traumstic event, the Modical Examinar mast be notified at Baltimore MD Rosedale 1 Yes No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 7923 Underhill Rd. 21237 USA permit. Pages 1 and 2 should be filed within 72 hours after death v. Department of Health and Mentel Hygiena. Important: if item 27 is marked other than "natural", or items 23a and Injury or other traumatic event, the Medical Examiner must page. Funeral 12. Was Decedant Evar In U,S Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14 Rece - Amarican Indian 1 Yes 2 No If Yas, Give Yeer or Dates: 1 Never Merried 2 Married 1 Yes 2♥ No Specify: white þ 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Meiden Sumame) 17. Father's Neme (First, Middle, Last) Walter G. Davis Catherine Weigmann 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 7923 Underhill Rd. Rosedale, MD Lorraine Stephens/daughter 20a. Method of Disposition 20b. Plece of Disposition (Neme of 20c. Location - City or Town, Stete cemetery, cremetory or other place Gardens of Faith Burial 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Specify) 9-4-98 Baltimore, MD 21. Signature of Eunerel Service Licenses 22. Name end Address of Fecility Cvach/Rosedale Funeral Home 1211 Chesaco Ave. Rosedale, MD 23a. Pert1. Enter the disease, or complications' that cause 1 1/4 death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximata Intervel Between Onset and Deeth **Physician** /Medical Immediate Causa (Finel disease or condition resulting in death) Examiner Physician/Medical Examiner ettending physician and for use as the bunel-transit Sequentially list conditions, if eny, leading to immadiate ceuse. Enter Underlying Cause (Disease or injury that initleted events resulting in death) Last Due to (or as a consequence of): Dua to (or as e consequence of): 88 ed by the detached 23b. Did tobacco usa contributa to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. signed by to d be detach 1 Yes 20 No 3 Probably 4 Unknown þ 24b. Ware eutopsy findings available prior to completion of cause of deeth? 24e. Was an autopsy performed? Completed been s has certificate ! 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medicel axaminar? Be 26. Plece of Deeth (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28e. Date of Injury (Month, Day Year) 27. Menner of Deeth 28d. Describe how Injury occurred 28c. Injury et Work? Certification: 28b. Time of 24 hours eftar death. Funeral Director: After 1 Neture 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ HomicIde

State Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifie

Paul Chang, MD

Medical

31. Date filed (Month, Dey, Year)

30. Name and address of person wito completed ceuse of deeth (Item 23e) (Type, Print)

Ravan 5601 och 32. Registrer's Signeture

Blod, Ste 107, Baltmore, MD 21239

🗺 Cartifying Physician: To the best of my knowledge, death occurred et the time, dete end placa, end due to the ceuse(s) and menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated.

29c. Licansa number

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29d. Date signed (Month, Day, Year)

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Baltimore, Maryland 21215-0020

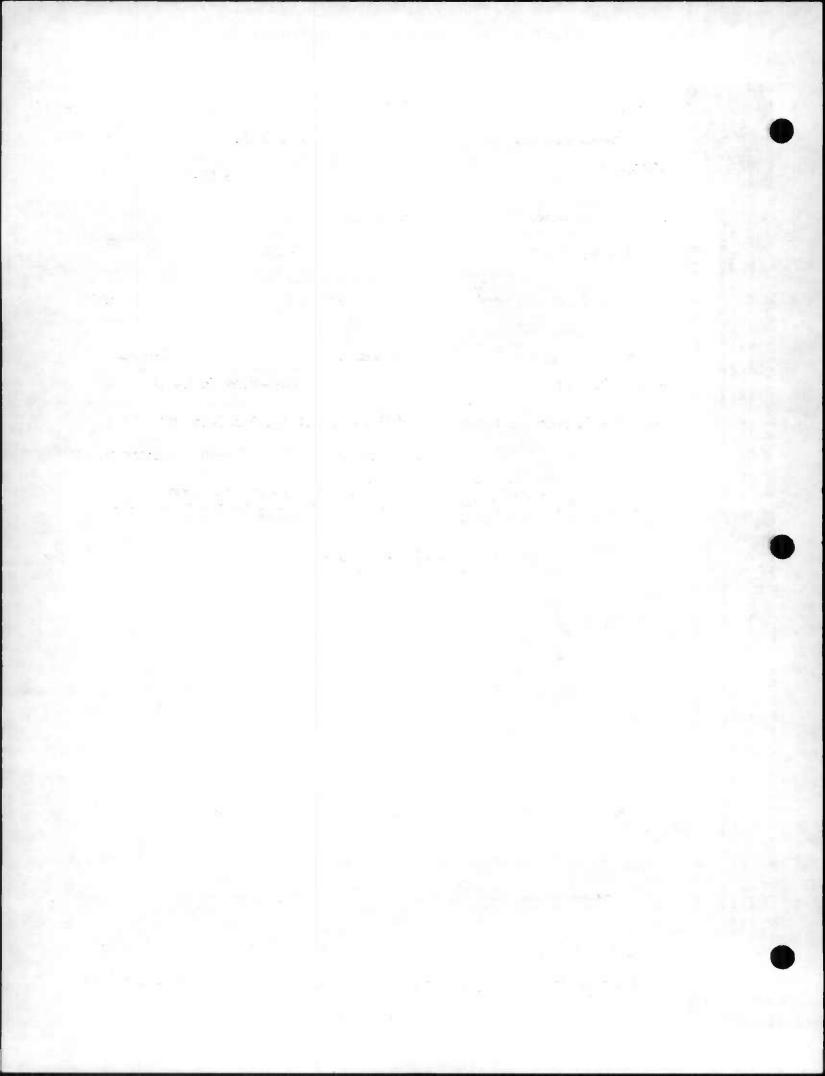
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Hospital or Attending

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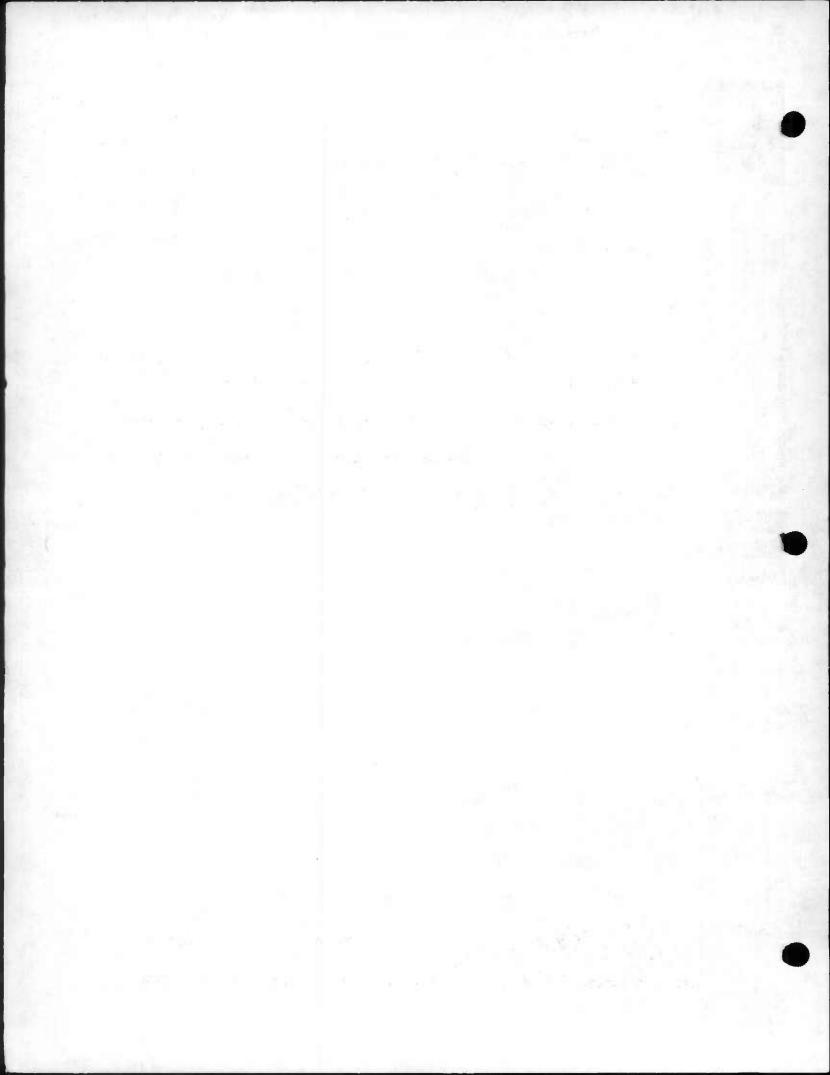
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State of Maryland / Department of Health and Mental Hygiene

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Departme Importan any Injur once.		21. Signature of Funerel Service Licentee 22. Name end Address of Fecility												
8 2 2 2		Dennier	Cvach/Rosedale Funeral Home 1211 Chesaco Ave. Rosedale, MD 23e. Pert1. Enter the disease, or complications thet caused he death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each lib. Approximate Intervel Between											
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DHMH 16 Rav 6/95



JOSEPH S. YOUNG SR.

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State of Maryland / Department of Health and Mental Hygiene

Physician
/Medical
Examiner
Funeral

Director the Meryland rel', or items 23a or 28a-f ehov Examiner must be notified at Directo Pages 1 and 2 should be filed within 72 hours after deeth with inner of Health and Mental Hygiene.

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Physician /Medical Examiner

Baltimore, Maryland 21215-0020

physician and s the burial-transit The law requires that the death certificate be executed Box 68760. attending p for use es 80 signed by the a P.O. Division of Vital Records, been signature has certificata Physician: director this After or Attending death. Director: A after within 24 hours To the Funeral I complately filled

Certificate of Death Reg. No. 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth Dey Month 30, 1998 AUG. 5:24 PM JOSEPH S. YOUNG, SR. 4b. City, Town, or Location of Death 4e Fecility Name (If not institution, give street end number) 4c. County of Death 1544 SULPHUR SPRING ROAD **ARBUTUS** BALTIMORE If Undar 24 Hrs. 8. Date of Birth
Hours Min. (Month, Dey, Year) If Under 1 Year 9. Birthplace (Stete or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days 1⊠M 2□F Months Yrs. MARYLAND 218-01-5743 FEB 2,1918 80 Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. inside City Limits 1 ☐ Yes 2 No ARBUTUS MARYLAND BALTIMORE 10f. Zip Code 10g. Citizen of Whet Country? 10e, Street and Number 21227 U.S.A. 1544 SULPHUR SPRING ROAD 12. Was Decedant Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Yaer or Dates: 1 ☐ Naver Married 2 ☑ Married 1 Yes 2 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11TH GRADE FOREMAN MANUFACTURING 18 Mother's Name (First, Middla, Melden Sumema) 17. Fathar's Name (First, Middle, Last) LULA MAY JOHNSON RICHARD AUGUSTUS YOUNG 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) 1544 SULPHUR SPRING ROAD - ARBUTUS, MARYLAND 21227 JUANITA YOUNG (WIFE) 20b. Pleca of Disposition (Name of cemetery, cremetory or other pleca) 20c. Location - City or Town, State important: if its any injury or oth 20e. Method of Disposition Date 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal trom Stata LOUDON PARK CEMETERY 9/2/98 BALTIMORE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE-BALTIMORE, MARYLAND 21229 4107 WILKENS AVENUE-BALTIMOR

23a. Part. Enter the bisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart tailure. List only one ceuse on each line. Approximate Interval Between Onset end Deeth Immediate Cause (Final disease or condition resulting in death) GUNSHOT WOUND TO HEAD Due to (or es a consequence of) Examiner Sequantially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence ot): Physician/Medicai Due to (or as a consequance of): 23b. Did tobacco use contribute to the cause of deeth? Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4♥ Unknown p 24b. Were autopsy tindings available prior to 24a. Was en eutopsy performed? Completed completion of cause of death? INSPECTION 1 ☐ Yes 200 No 1 ☐ Yes 2 ☐ No 25. Was case reterred to medical examiner? Be 26. Piece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 N Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Date of Injury (Month, Dey Yeer) 8-30-1998 FOUND 28b. Time ot 28d. Describe how injury occurred 27, Manner of Death 28c. Injury et Work? Certification: 5 Pending 1 Natural 1718 P SUBJECT SHOT SELF 1 ☐ Yes XX No investigation 2 Accident 6 Could not be determined 3 XX Suicida 28f. Location (Street and Number or Rural Routa Number, 157ff or Town, State)
15RBUTUS PHORESPRING ROAD
ARBUTUS PHORESPRING ROAD Placa of Injury - At home, tarm, street, factory, office building, etc. (Specify) 4 Homicide RESIDENCE 1 Certifying Physician: To the best of my knowledga, daath occurred at the time, date and place, end due to the cause(s) and mannar es stated. 29a. Certifie edical Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the tima, date end placa, and due to the cause(s) end manner stated. (Check only one) 29c. Licansa number 29d. Date signad (Month, Day, Year) 29b. Signature and title of certifier AUG. 31, 1998 O.C.M.E 30. Neme and address of person who completed cause ot death (Item 23e) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 Margarita Korell M.D.

Darks

State Registrar

31. Dete tiled (Month, Day, Year) SEP 0 4 1998

32. Registrer's Signature

32. Registrar's Signatura

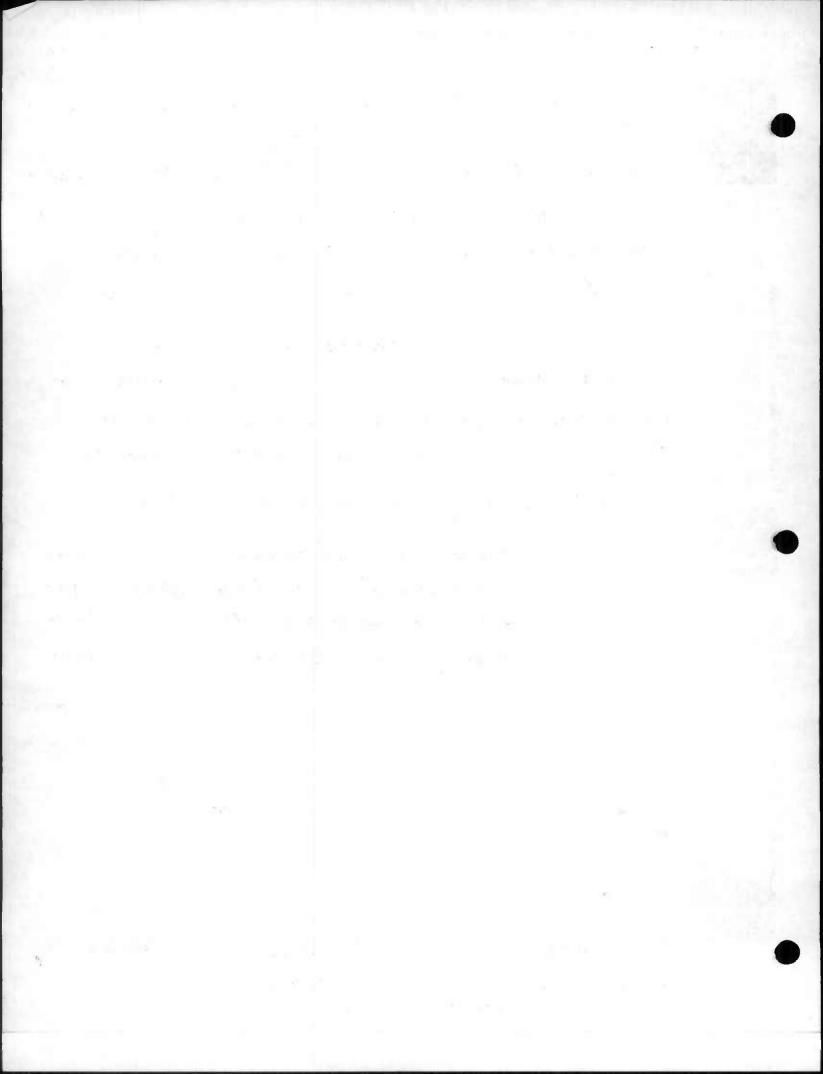
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State of Maryland / Department of Health and Mental Hygiene

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Thomas Funeral Home PA 700 Locust St. Cambridge MD 21613 23e. Pert, Erise the disease, or complications that caused the selfs. Do not enter the mode of dying, such as cardiac or respiratory errest. Approximate constitution and the selfs. Do not enter the mode of dying, such as cardiac or respiratory errest. Approximate constitution and the selfs. Do not enter the mode of dying, such as cardiac or respiratory errest. Approximate constitution and the selfs. Do not enter the mode of dying, such as cardiac or respiratory errest. Approximate constitution and the selfs. Do not enter the mode of dying, such as cardiac or respiratory errest. Approximate constitution and the selfs. Do not enter the mode of dying, such as cardiac or respiratory errest. Approximate constitution and the selfs. Do not enter the mode of dying, such as cardiac or respiratory errest. Approximate constitution and the selfs. Do not enter the mode of dying, such as cardiac or respiratory errest. Approximate constitution and the selfs. Do not enter the mode of dying, such as cardiac or respiratory errest. Approximate constitution and the selfs. Do not enter the mode of dying, such as cardiac or respiratory errest. Approximate constitution and the selfs. Do not enter the mode of dying, such as cardiac or respiratory errest. Approximate constitution and the selfs. Do not enter the mode of dying, such as cardiac or respiratory errest. Approximate constitution and the selfs. Do not enter the mode of dying, such as cardiac or respiratory errest. Approximate constitution and provided in the selfs. Do not enter the mode of dying, such as cardiac or respiratory errest. Approximate constitution and provided in the selfs. Do not enter the mode of dying, such as cardiac or respiratory errest. Approximate constitution and provided in the selfs. Do not enter the mode of dying, such as cardiac or respiratory errest. Approximate constitution and provided in the selfs. Do not enter the mode of dying, such as cardiac or respiratory errest. Approx			Dorchester Memorial Park 8/26/98 Cambrid											
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State of Maryland / Department of Health and Mental Hygiene 🔾 Certificate of Death

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1998

4c. County of Death

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3. Time of Death

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Physiciar /Medica	PONALD DELLA DEPNARDA A	Dete of Deet Month
Examine	4b City Town or Locality	on of Deeth
Funeral Director	OAO AO OAEA ITAN STE E1 Months Deys Hours Min.	Dete of Birth (Month, Day, rch 25
the Maryland 28a-f ehow	Usuef Rasidence of Decedent 10a. Stete 10b. County 10c. City, Town or Location Maryland Washington Hagerstown	
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Baltimore, Maryland 21215-0020 semit. Pages 1 and 2 should be filed within 72 hours at begarment of Health and Mental hygiene. Important: If Nem 27 is marked other than "patural; or my injury or other traumatic event, tre Madical Examinate.	15. Decadent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Sales Operations Manager	
iore, Maryland 21215-0 ges 1 and 2 should be filed within 72 h. t of Health and Mental Hygiene. If item 27 is marked other than "nature or other traumatic event, tre Medical	Sales Operations Manager 17. Fether's Nema (First, Middle, Last) Sales Operations Manager 18. Mother's Nama (Fi	irst, Middla, I
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Baltimore, Maryland 21215-002 semit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. moortant: If flem 27 is marked other than "natural", any injury or other traumatic event, traumatic all and	20e. Method of Disposition 1 Burial 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Specify)	-98
Baltimo permit. Pag Department Important: I any injury o	21. Signetura of Funaral Service License And Tew R. Collinian Fun 40 East Antietam Stre	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be deteched for use as the buriel-transit And first Certification: TO Be Completed by Division Medical Exeminer	Immedieta Causa (Finel disease or condition resulting in deeth) e. Intrackantal Hemorrha Due to (or es e consequence ot): b. Carotid Stansis Due to (or es e consequence of): Due to (or es e consequence of): Couse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of): Couse (Disease or Injury that initiated events resulting in deeth) Lest	GE_
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Division of Vital Records to the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		. Describe h
Division of the or Attendate death Director: / 3 in by the feet	3 Suicide 6 Could not be detarmined 28e. Plece of Injury - At home, farm, street, factory, office 28f.	
To the Hospital or within 24 hours aft completely filled in	4 Homicide building, atc. (Specify)	Location (S City or Town

gerstown Washington er 24 Hrs. 8. Dete of Birth s Min. (Month, Day, Year) March 25,1947 9. Birthplace (Stete or Foreign Connecticut 10d. Inside City Limits 1X Yes 2 No 10g. Citizen of Whet Country? U.S.A. 14. Race - American Indien, Bleck, White, etc. Origin? (Specify Yes or No-an. Puerto Rican, etc.) Specify: White 16b. Kind of Business/Industry ost of working Redland Brick Co. anager ther's Nama (First, Middla, Maiden Sumame) Luchina Marv ber or Rural Route Number, City or Town, State, Zip Code) 11 Circle, Hagerstown, Md. 21740 20c. Location - City or Town, State Date East Hartford Connecticut 08-22-98

2. Dete of Deeth Month

Man Funeral Home, Inc. tam Street, Hagerstown, Md. 21740 es cardiac or respiratory errest, Approximete Intarvel Between Onset end Death

2 hours

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24e. Was en eutopsy

24b. Were eutopsy findings eveilable prior to complation of cause of deeth?

2 No 1 ☐ Yes 26. Plece of Death (Check only one)

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

Other: 4 Nursing Homa 5 Residence 6 Othar (Specify)

Location (Street and Number or Rural Route Number, City or Town, State)

12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, data end piece, end due to the ceuse(s) and mennar as statad.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, daath occurred et the time, date and piaca, and dua to the ceuse(s) end menner steted. 29d. Date signad (Month, Day, Year)

29b. Signeture end title of certifier

29c. License number 0052054

30. Name and addrass of person who completed cause of deeth (Item 23a) (Type, Print)

BERNHAKMI NECHAMA

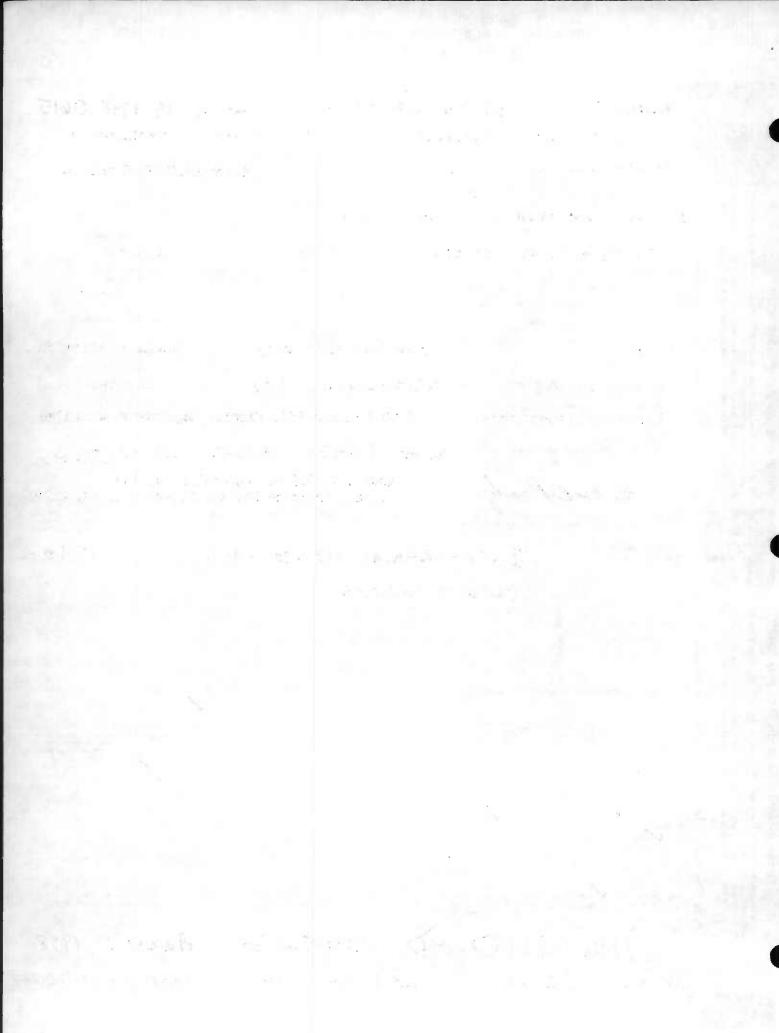
322 E. ANTIETAM ST, HAGEKLYOWN, MD 21740

State Registrar

31. Date filed (Month, Day, Year)

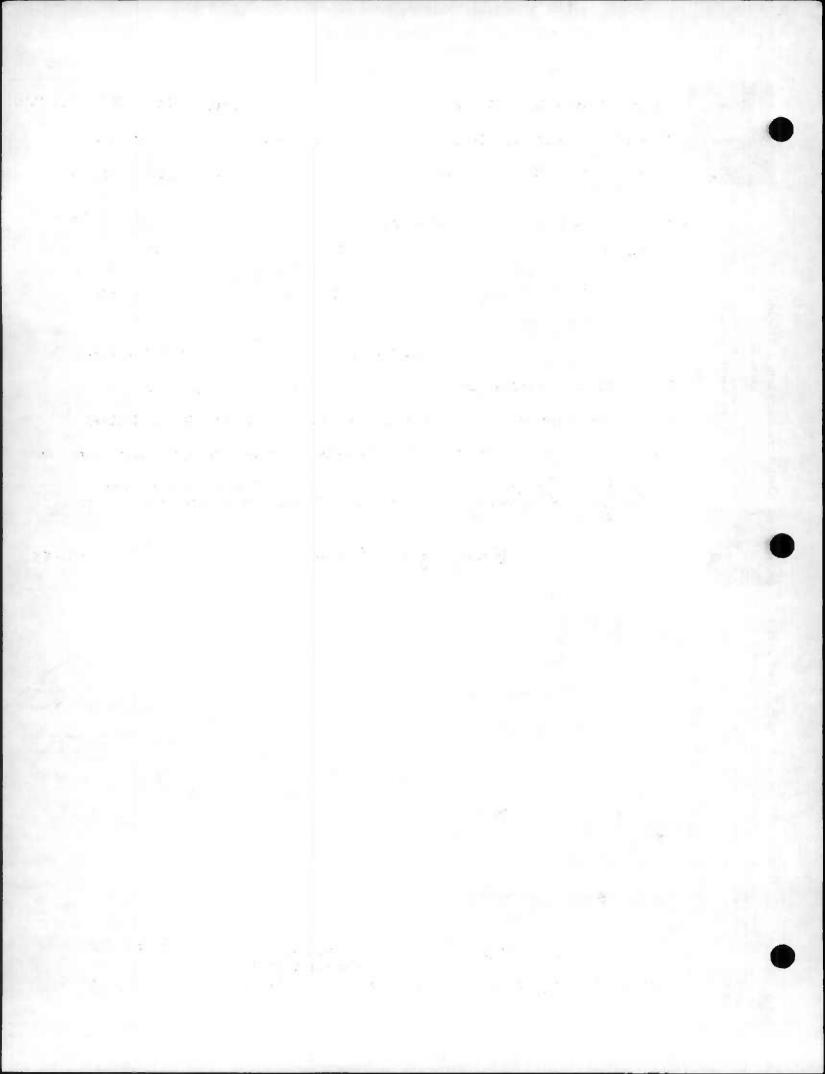
AUG 2 4 1998

32/ Registrer's Signature



State of Maryland / Department of Health and Mental Hygiene 9 8 27 18 9

					Ce	rtifica	te of	Death			Reg. No.	0	1105		
1		ne (First, Middle, Li								2. Dete of De Month		Vear	3. Time of Death		
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Examiner	to Facility Nome !	If not institution, gi	ve street end nu	ımber)				4b. City, To	own, or Lo	ocation of Death	4c. Coun	ty of Deeth			
€	Frederi	ck Memor	ial Hos	pital				Frede	erick	ζ	Fre	derick			
Funeral Director	5. Social Security # 218-38-		Sex 1☐M 2☐F	7. Age (In yrs. 56		Months	r 1 Year Days		24 Hrs. Min.	8. Date of Bird (Month, De Jan. 4	h y, Year) 1942	9. Birthpi Count Mary 1	ace (Stete or Foreign ry) and		
2	Usuel Residence	_													
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23ª or	7 Poplar						1773	3			US	A			
r da	11. Marital Stalus		Armed F		J,S. 13.	Wes Dece If Yes, spe	dent of cify Cub	Hispenic Or en, Mexice	igin? (Sp n, Puerto	ecify Yes or No Rican, etc.)		ece - America leck, White, e			
ges 1 end 2 should be filed within 72 hours after death with the Maryland it of Health and Mentei Hygiene. It of Health and Mentei Hygiene. or other traumatic event, the Medical Examiner must be notified at the order traumatic event, the Medical Examiner must be notified at To Re-Completed by Euraval Director.	1 Never Man	ried 2 Merried 4 ☐ Divorced	1 Yes If Yes, G Year or I	2 XNo ive Dates:		1 🗆 Yes	2 (X No	Specify	:		Spec	eity: Whit	e		
d within 72 hours at giene. If the "natural", or the Medical Example Completed by 8	(Ѕре	15. Decedent's E cify only highest gr			16e. Dece	dent's Usu	el Occu	pation during mos	st of work	ing	16b. Kind of	Business/Ind	ustry		
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and 2 alth a 27 is	June Bar	thlow/sp	ouse		7 Pop	lar S	Stre	et, My	yersv	ville, N	Marylan	d 2177	3		
of He item	20a. Method of Dis	,		20b.	Plece of Disp	osition (Ne	me of	ace)		Date	20c. Locetion	n - City or To	wn, Stete		
permit. Pages 1 and 2 sh Department of Health and Important: If Itam 27 is n eny injury or other traun ong.		. Liberton (Green)									8-27-98 Myersville, Maryland				
Department Pa Department Important: Pary Injury	21. Signature of	Peral Service Lice	nsee		2	2. Name a	nd Addr	ess of Fecili		ketts 1	Funeral	Home			
00500	504 Main Street, Myersville, Maryland 21773														
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Physician													Onset and Death		
/Medical Examiner	Immediale Ceuse diseese or condition	n	· E	Soph	oceal	C	an	مه					Years		
	resulting in deeth)			Due to (or es e conse	quence of	:								
nsit	CET CLES		b												
al-trar	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or Injury Couse (Disease or Injury														
siciar buri	Cause (Disease or thet initiated event	erlying r injury	c			-0						1			
antificate be executed ing physician and e as the burial-transit	resulting in deeth)			Due to (or as a conse	quence or)									
requires that the deeth certificate be executed seen signed by the ettending physician and ihould be datached for use as the burial-transit eted by Physician/Medical Examin			d		-			<u> </u>			·				
at the deeth cod by the ettend stached for us	Pert II. Other signi	ficant conditions	contributing to d	leath but not res	sulting in the	underlying	ceuse gi	iven in Pert	I.	23b. Did	tobacco use	contribute to	the cause of death?		
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signed d be dal										0.6- 144		Toth We	re eutenou tindings		
The law require sate has been single 2 should Completed											en eutopsy rmed?	COL	re eutopsy tindings silable prior to appletion of ceuse		
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or Attendi effer death Director: A d in by the f	2 Accident 3 Suicide	6 Could not be	oo Dies	e of Injury - At h	ome, ferm, si					28f. Location (Street end Nu	mber or Rura	Route Number,		
tal or Attending P rs efter death. at Director: After ted in by the funeral led in by the funeral Certification:	4 Homicide	determined	build	ling, etc. (Speci	<i>(y)</i>					City or To	vn, Stete)				
To the Hospital or Attending Ph within 24 hours efter death To the Funeral Director: After th completely filled in by the funeral Medical Certification:		1 Certifying Pt	miner: On the b	e best of my kno besis of examine oner steted.	owledge, dee etion end/or in	th occurred	et the t	ime, dete er opinion, dec	nd plece, eth occuri	end due to the red et the time,	ceuse(s) end date end plec	menner as st e, end due to	eted. the ceuse(s)		
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Registrar	AU	G 27 199	8	eneral	Ø.	100	uks								

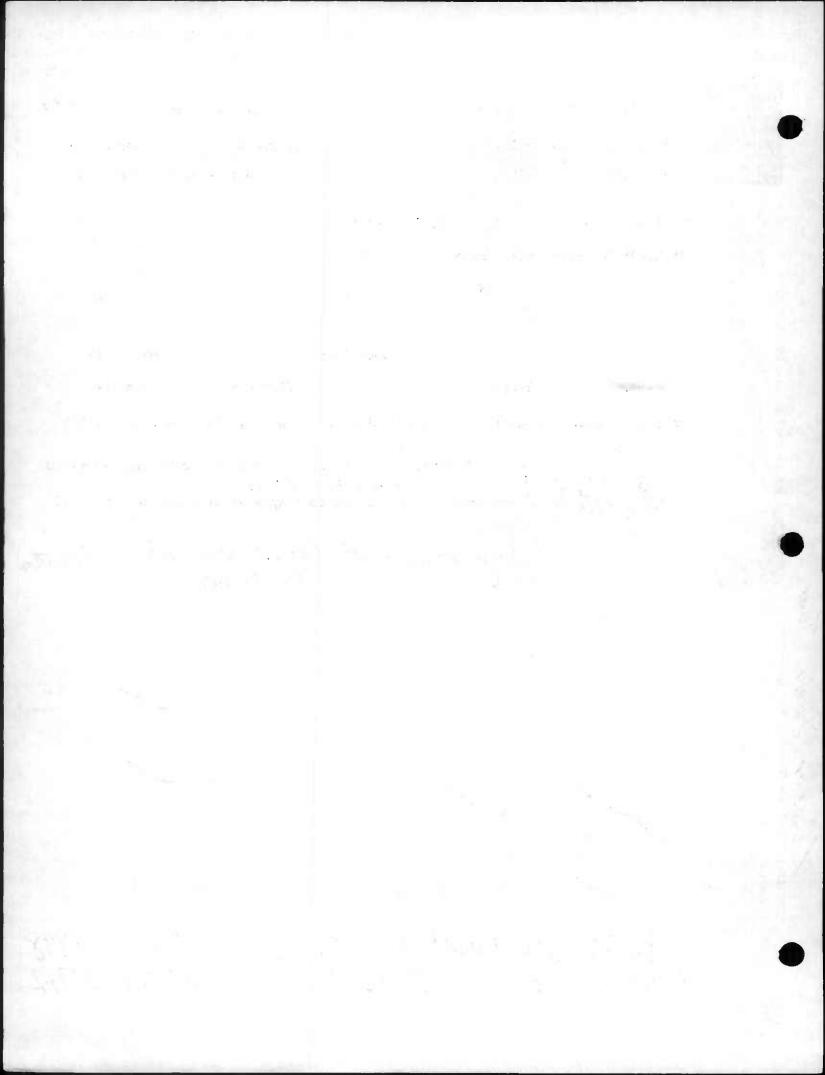


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Emma Jane Bowser AUGUST /Medical 4a. Fecility Nama (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Washington County Hospital Hagerstown
If Under 24 Hrs. 8. [
Hours Min. (Washington if Under 1 Year 5. Social Security Number 8. Date of Birth (Month, Dey, Year) Oct.24,1923 7. Age (In yrs. lest birthday) **Funeral** Birthplace (State or Foreign Country) Months Deys 1 M 200 219-14-7928 74 Yrs Director Maryland Usuel Residence of Decedant 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Washington Maryland Williamsport 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 15 North Conococheague Street 21795 USA by Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ZWNo If Yes, Giva Year or Dates: 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxicen, Puerto Ricen, etc.) 14. Rece - American Indien, Black, White, etc. XXNever Married 2 Married 1 Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT usa ratired) 15. Decedant's Education (Specify only highest grade complated) 16b. Kind of Business/Industry Elementary/Secondery (0-12) Collaga (1-4or 5+) 12 Secretary Government 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Be B. Virginia John Maurice Bowser Conley 19e. Informent's Name/Ralationship (Type, Print) 19b. Mailing Address (Straat end Number or Rurel Route Number, City or Town, State, Zip Code) Stanley Anderson/Personal Rep. 21723 O'Toole Drive Hagerstown, Maryland 21742 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, Steta 1 Burial 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Spenty Smithsburg Crematory 8-26-98 | Smithsburg, Maryland 22. Name and Address of Facility
OSborne Funeral Home 425 S.Conococheague St.Williamsport, MD 21795 The disbasa, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, art feilura. List only one ceusa on each lina. shock, or h **Physician** the lungs Immediata Causa (Final disease or condition resulting in daath) /Medical Mamous Examiner Dua to (or es e consequence of): Examiner Physician: The law requires that the death certificate be executed the buriel-transit Sequantially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting In death) Lest Due to (or es e consequence of): signed by the ettending physiclan d be detached for use es the bune Box 68760 Physician/Medicai Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown of Vital Records, Completed by should ! 24b. Wara autopsy findings aveileble prior to completion of cause of daeth? 24e. Wes en autopsy performed? hes or Attending Physician: The after death.

Director: After this certificate 1 🗆 Yas 1 ☐ Yes 2 ☐ No director, Be 25. Was case rafarrad to 26. Pleca of Death (Check only ona) exeminar' Hospital: 1 Hopatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 28e. Date of Injury (Month, Dey Year) in by the funerel 27. Menner of Deeth 28c. Injury et Work? 28d. Describe how injury occurred Certification: 28b. Time of Division 5 Panding investigation 1 Natural 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 4 ☐ Homicide within 24 hours a To the Funeral D completely filled 29a. Cartifian Medical 14 Certifying Physician: To the best of my knowledge, deeth occurred et the time, data and plece, and due to tha cause(s) and menner es steted. 2 Medical Exeminer: On the besis of examination end/or Investigation, in my opinion, death occurred et the time, date end piece, end due to the cause(s) end menner stated. the 29d. Date signed (Month, Dev. Year th (Itam 23a) (Type: Print) Robert 31. Date filed (Month, Day, Year) 32. Registrer's Signeture State AUG 28 1998 Registrar

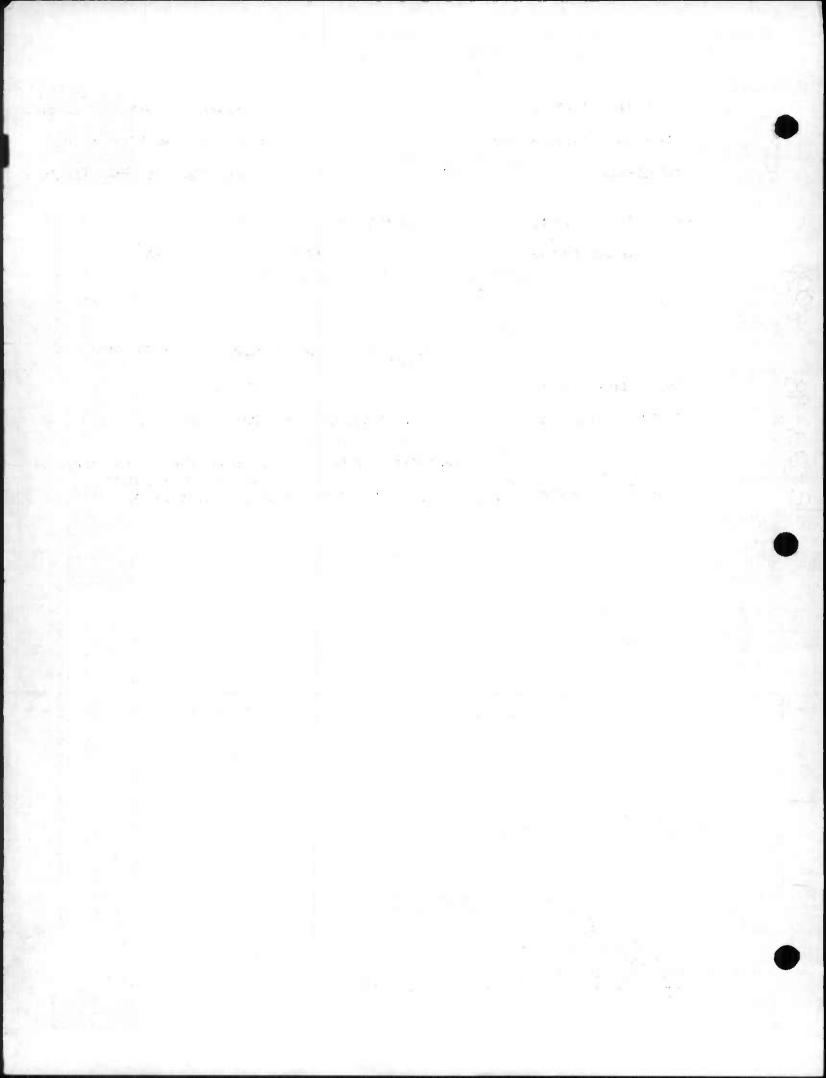
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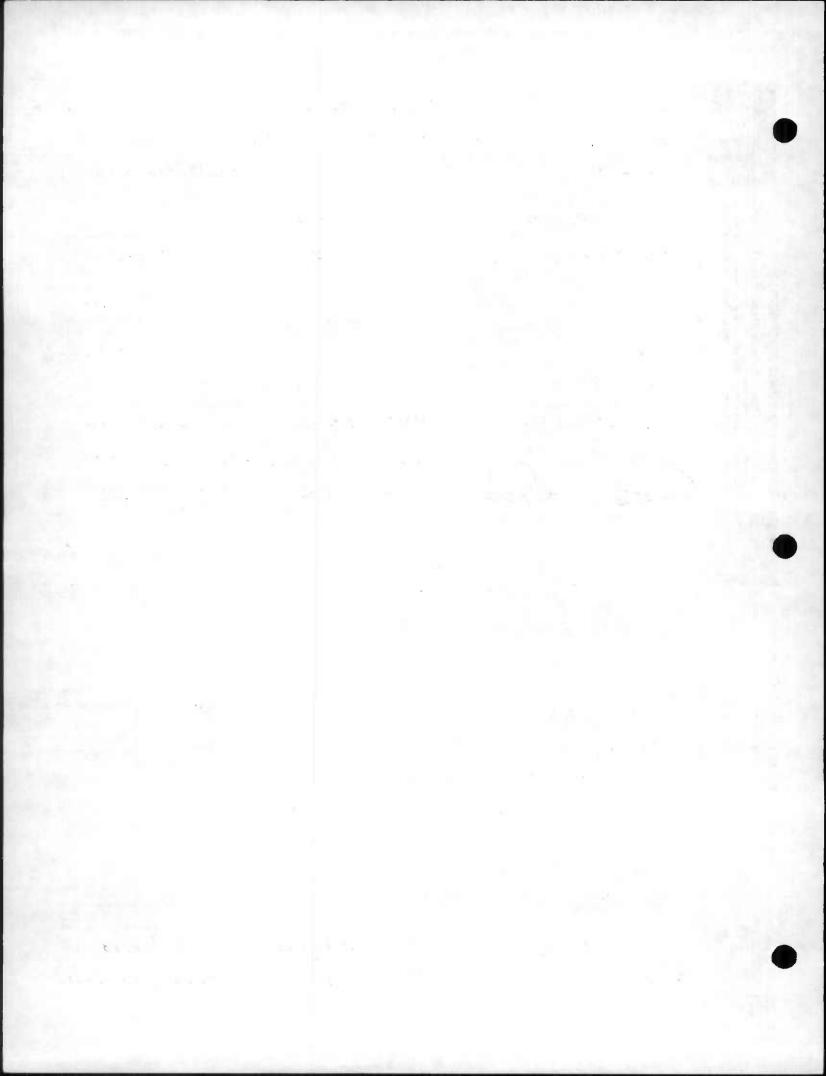
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2 Date of Deallugust 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) **Physician** Jober tatic 1:05 Am /Medical 24 Hrs. 8. Date of Byth (Month, Dey, Year) 19 Hrnary 9, 1929 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Name (If not institution, give street and number, Examiner Prince Washington Hospital 7. Age (In yrs. lest birthday) beordes 6. Sex] 1☐M 2☐ F If Under Months 9. Birthplece (State or Joreign Country) Maryland 5. Social Security Number **Funeral** 69 219-56-1149 Director Usual Residence of Deceden 10d. Inside City Limits 10a Slate 10c. City, Town or Location 10b. County 1 Yes 2 No Directo Maryland Charles Indian Head 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? Patrick But P.O. Box 1202 20640 USA Funeral 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Raca - American Indien, 11 Marital Status the Medical Examiner Bleck, White, etc. 11♥ Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give 1 Yes 2 No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Farmer Self-Employed 18. Mother's Name (First, Middle, Meiden Surneme) 17. Fether's Neme (First, Middle, Last) Be Pages 1 and 2 should be Robert P. Butler Sr. Ella Butler 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Tobert Health Ella Washington- niece 3506 Holloway North Upper Marlboro, Maryland 20772 reportant: If item 27 ny injury or other to 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) Date 20c. Location - City or Town, Stete õ 1 XBurial 2 ☐ Cremation 3 ☐ Removel from Stete ST. Marys Cemetery August 27,1998 Bryantown, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Neme end Address of Fecility 21. Signature of Funeral Service Licans Adams Funeral Home Aquasco, Maryland 20608 23a. Pert1. Enter the disease, or complications that daused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or hear 1 filiure. List only one cause on each line. Approximete Interval Between Onset and Death Physician TASTATIC SARCOMA /Medical Immediate Ceuse (Final disease or condition resulting in deeth) Examiner SARCOMA Examiner physician and the burial-transit The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events.) Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical thet initieted events resulting in deeth) Lest Due to (or es e consequence of) 88 980 signed by the e Pert II. Other algnificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown OBS PULMONARY ò 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy Completed ANEMIN Is certificate has director, page 2 1 ☐ Yes 2 X No 1 □ Yes 2 □ No To the Hospital or Attending Physician: within 24 hours efter death. To the Funeral Director: After this certifica completely filled in by the funeral director, it 25. Wes case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury et Work? 1 Neturel 2 Accident 5 Pending 1 Tyes 2 No investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 4 ☐ Homlcide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. — Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edicai (Check only one) 29d. Dete signed (Month, Day, Year) 29c. License number 29b. Signature end title of cartifie

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State Registrar 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

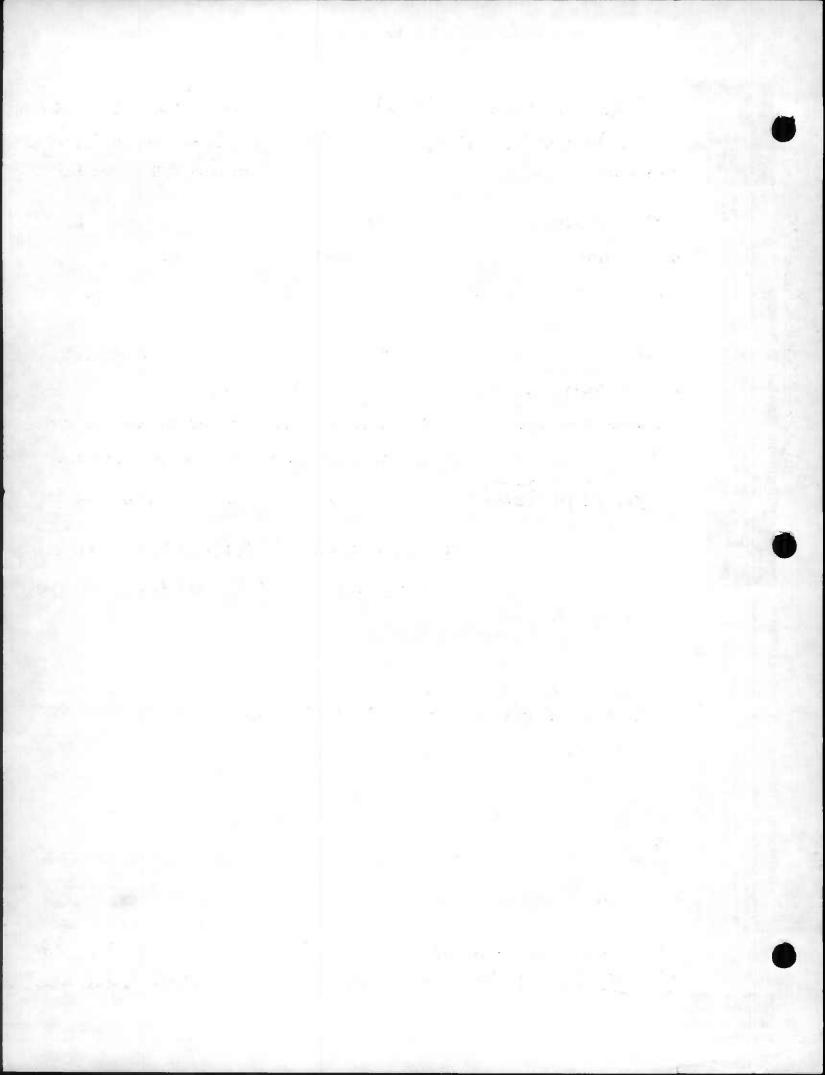
1998

32. Registrer's Signature

Sewch

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31. Dete filed (Month, Dey, Year)



Piease Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 80, 1998 waso /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Maryland beordes Aga (In yrs. last birthday) If Under 1 Year 5. Social Security Number 6. Sax 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 XM 2 ☐ F Director 220-38-1616 19,1944 Feb. Washington DC Usual Residence of Decedent the Manyland 10a, State 10b. County 10c. City, Town or Location -how 10d. Inside City Limits r than "naturel", or items 23s or 28s-f sho the Wedical Examiner must be notified at 1 ☐ Yes 2 No Maryland Prince George's Director Upper Marlboro 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code with 15100 Nottingham Road 20772 U.S.A. deeth Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 1963- Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or item only Injury or other treumatic event, the Medical Examination. Black White etc. 1 XYes 2 No
If Yes, Give 1967
Year or Detes: 1 ☐ Never Married 2 X Merried altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Mechanic - Trucking Co. Owner - Self-Employed N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Edna May Guthrie 2 Gordon Lytle Bartoo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Bartoo (Wife) 15100 Nottingham Road Upper Marlboro, MD 20772 20b. Plece of Disposition (Name of 20c. Location - City or Town, Steta 20a. Method of Disposition cematery, cremetory or other place) 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State August23, 4 ☐ Donation 5 ☐ Other (Specify) Lee Crematory Clinton, Maryland 1998 Lee Funeral Home, Inc. 21. Signeture of Funerel § 22. Name end Address of Fecility 6633 Old Alexandria Ferry Road Clinton, MD 20735 23a. Part. Effer the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medicat Immediate Cause (Finel disease or condition resulting in death) Examiner Physician/Medical Examiner physician and s the burial-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e co Box 68760. Due to (or es a consequence of): P.O. Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Onknown 1 ☐ Yes 2 ☐ No Records. by D od The lew requires 24b. Were autopsy findings available prior to completion of cause of death? pinous 24a. Wes an autopsy performed? Completed pege 2 500 2000 1 ☐ Yes 2 ☐ No 1 Yes Division of Vitai Attending Physician: 80 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 1 Yes 2 No 1 Inpatient 2 PR/Outpatient 3 DOA this 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending investigation 1 Matural death. 1 Yes 2 No 2 Accident ne Hospital or Attendi n 24 hours efter death ne Funeral Director; A pletely filled in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. To the I within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D21173 August 25, 1998 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

Registrar

State

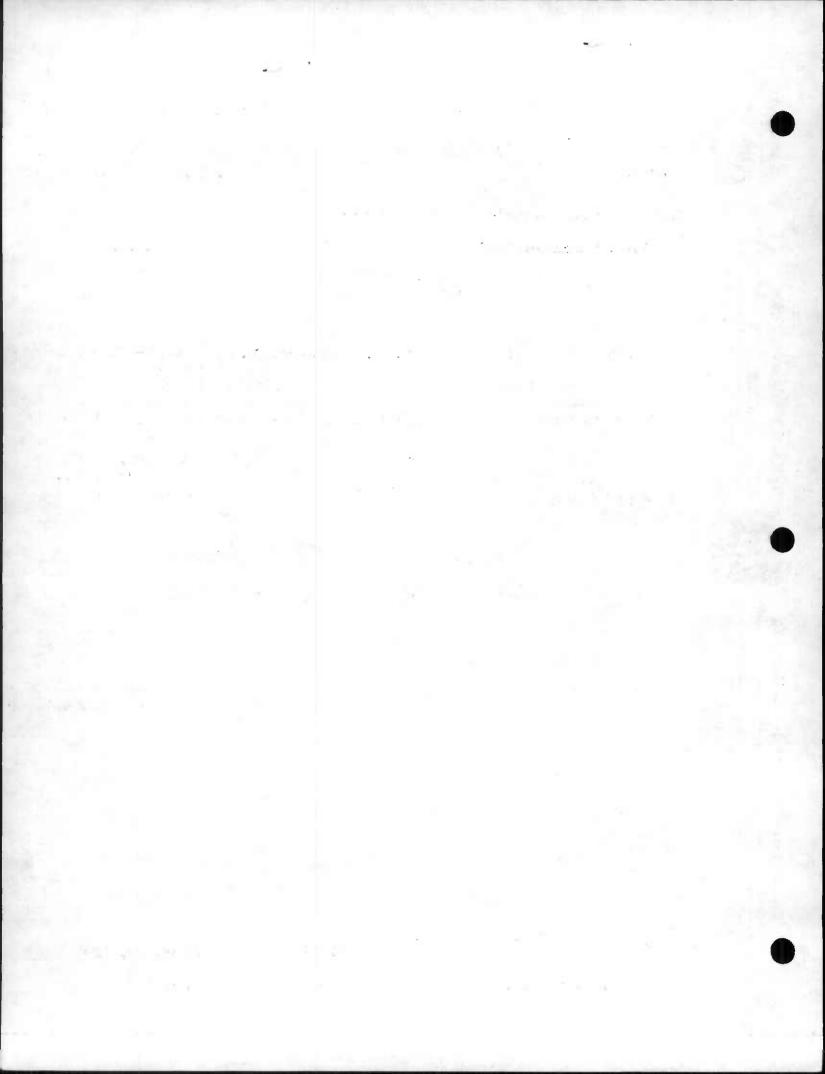
Niran P. Sharma M.D.

AUG 26

31. Date filed (Month, Day, Year)

32. Registrar's Signeture

11345 Pembrooke Square Waldorf, MD 20603



TWIN B BABY GIRL APAIL MCDOWELL

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Piease Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Day **Physician** August 20, 1998 12:45 AM William Clayton Caskey /Medical 4e. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Williamsport | Will Homewood Nursing Center 5. Social Security Number 7. Age (In yrs. lest birthday) Birthpleca (Steta or Foreign Country) **Funeral** Months 1₽M 2□ F 83 214-09-1070 Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10e. Stete 10b. County i Hygiere. other than "ratural", or items 23s or 28s-f show went, the Medical Exeminer must be notified at 10d. Insida City Limits Washington Maryland Hagerstown 1 ☐ Yas 2 ☐ No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1307 Hamilton Boulevard 21742 USA Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Spacify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indien, 11. Meritei Stetus Bleck, White, atc. Armed Forces:
1 Jyes 2 No
If Yes, Give
Yeer or Detas: 1943-45 1 Nevar Married 2 Married 1□Yes 2□No Specify: Specify: A 3 ☐ Widowed 4 ☐ Divorced White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Coilege (1-4or 5+) 12 Lab Technician Cement Company 17. Fathar's Nema (First, Middla, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be should be ind Mental Harry Clayton Caskey is marked Inez Strode 2 19e. informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Steta, Zip Code) Pages 1 and 2 s nent of Health an important: If Item 27 any injury or other tr Martha Josephine Caskey/Wife 1307 Hamilton Blvd., Hagerstown, Maryland 21742 te of Disposition (Neme of 20c. Location - City or Town, Stete 20b. Plece of Disposition (Neme of cemetary, crematory or other plece)
St. Paul Cemetery 20e. Method of Disposition 1 Burlel 2 Cramation 3 Removel from Stata 4 Donation 5 Other (Spacify) Aug.24 Clear Spring, Maryland 22. Name end Address of Fecility Douglas A. Fiery Funeral Home 21. Signatura of Eunarai Sarvice Co. 1331 Eastern Blvd.North, Hagerstown, Maryland 21742 Approximata Intervel Between Onset and Death 23a, Part1 is thet caused the deeth. Do not enter the moda of dying, such as cerdiac or respiretory errast, Physician immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or es e consequence of) Examiner signed by the ettending physician and d be detached for use as the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that in listed events. Due to (or es a consequence of): Physician/Medical that initieted events resulting in deeth) Lest Dua to (or as a consequance of) Pert II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 20 No 3 Probably 4 Unknown by page 2 should 24e. Wes an autopsy parformed? 24b. Were autopsy findings Completed avellable prior to completion of cause of death? certificate has 1 🗆 Yes 1 ☐ Yes 2 ☐ No 25. Wes case referred to medicel exeminer? Be 26. Place of Deeth (Check only one) 1□ Yes 2 No Other: 2 1 Inpatiant 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Othar (Specify) After this funeral 27. Menner of Deeth Certification: 28e. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred Netural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director: 8 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Spacify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 6 To the Hospital within 24 hours or To the Funeral Completely filled 29e. Certifier Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piace, and due to the cause(s) (Check only one) end menner stated. 29b. Signeture and title of 29c. License number 29d. Date signed (Month, Day, Year) completed ceuse of deeth (Item 23e) (Typa, Pripa Alen

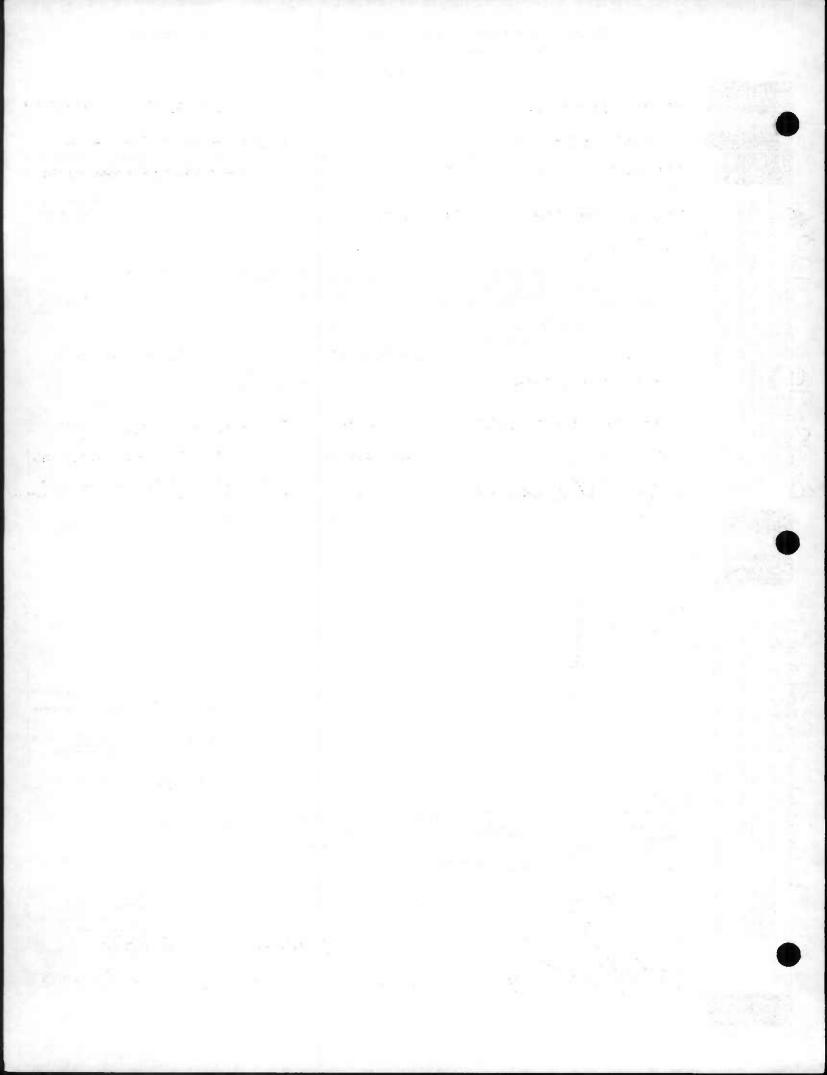
State Registrar

31. Dete filed (Month, Dey, Year)

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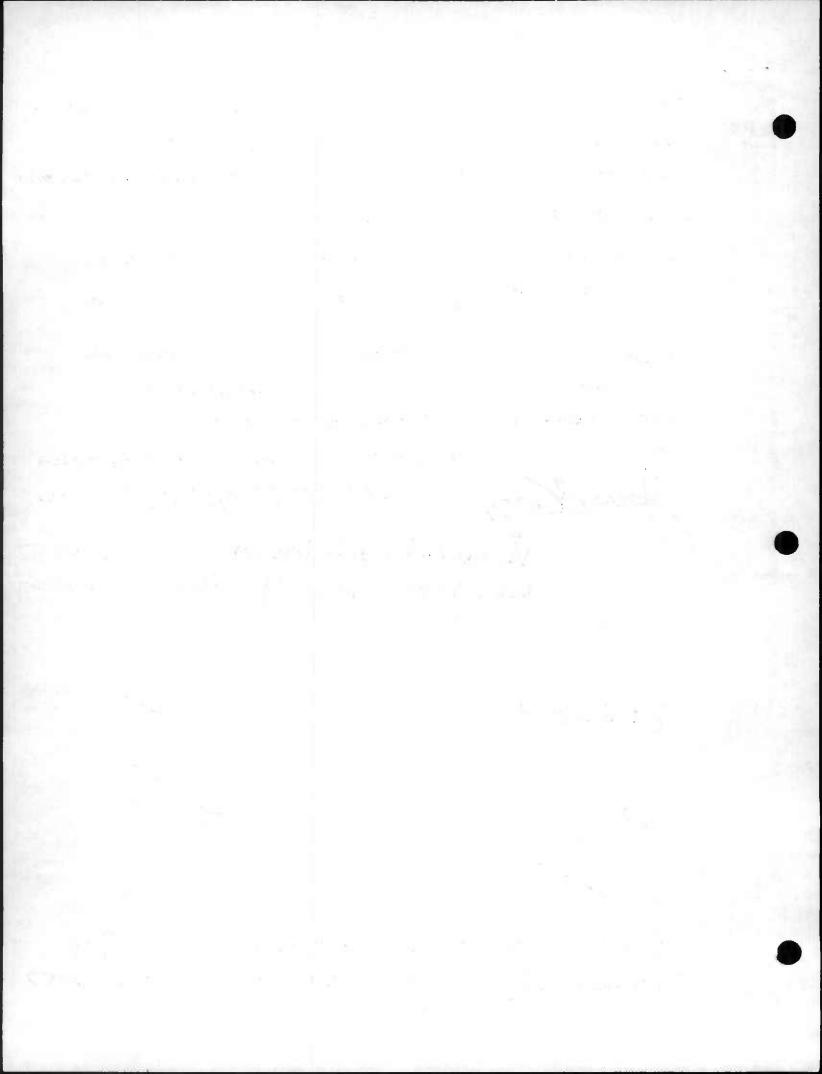
1998

\$2. Registrer's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	,					C	ertificate d	of Death		Reg. No.) (1191
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	Physic /Medi		Paul C. Crone						Aug		998	1:30 AM
	Examir		4a. Facility Name (If not institution, gi	ive street and numbe	r)			4b. City, Town,	or Location of Death	4c. County	of Death	
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	Funeral Director		225-36-7740	Sex 7. A	74	s. last birthda Yrs.	Months Da		in. (Month, Da	th y, Year) , 1924		olace (State or Foreign otry) Virginia
	pue #		Usual Residence of Decedent 10e. State 10b. County		10c. C	City, Town or	Location		_		1	0d. Inside City Limits
	fatho fatho	ò	Maryland Carroll			•						1 ☐ Yes 2 🛣 No
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a	chould be of Mental marked of marked ev	OB	Jacob Crone					Emma	Frances (Clinomar	1	
Maryland	W	-	19a. Informent's Name/Relationship	(Type, Print)		19b. Ma	lling Address (Str		Rural Route Number			Code)
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=	F 4 3		21. Signature of Funeral Service Lice	**			22. Name and Ad		0/20	Garri	5011	Haryranu
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-	_		234 Parti. Enter the disease, or cor	Indications that rates	nd the de	oth Do not a	1212 W.	Old Libe:	rty Road	Winfie	1d, M	
	Ob lala		Paul. Enter the disease, or cor stuck, or heart failure. List only	one cause on each	line.	stri. Do not s	inter the mode of	dynig, such es card	nac or respiratory a	11031,	1	Approximate Interval Between Onset end Death
	Physician /Medical		Inv. ediete Cause (Final	Von	Ti	culo	1 Ail	illati	M			Quetant
	Examiner		seese or condition resulting in death)	a V C co		(or as a cons						Consta
-	p #	ner		CON	a	erlic	lo He	2 aur	faill	up		6 arrance
	death certificata be executed e attending physician and of for use es tha burial-transit	Examine	Sequentially list conditions,		Dupty	(or as a cons	equenca of):					V
Š,	e executar sian a		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury									
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	the a	Physician/	Part II. Other significant conditiona	contributing to death	but not re	sulting in the	underlying cause	given In Part I.	23b. Did	tobacco use co	ntributa to	the cauaa of death?
J.	thet the de led by the a	Phy	JIDEM	IA					1 🗆	Yes 2 Ne	3 □ Prof	bably 4 ☐ Unknow
Ś	es the igned be de	þ	O RI	110					_			
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	0 4 0	Eo							10	Yes 2 ILNO	10	Yes 2 No
VII a		0	25. Was case referred to medical	T	_			26. Place of D	Deeth (Check only o			
>	7	OB	examiner? 1 ☐ Yes 2 7 No	Hospital:	ient 2[☐ ER/Outpati	ent 3 DOA	Other:	Home 5 President		er (Specif	iv)
O	g Phys er this seral di	- i	27. Manner of Death	28a. Date of in (Month, D		28b. Time Injury		njury et Work?		how injury occur		
ō	Attending or death. ector: After by the fune	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation		ay rear,	Hijuty		Yes 2 No				
DIVISION	ii or Attending Phy after daath. I Director: After this d in by the funeral of	Certification:	3 Suicide 6 Could not to determine		ijury - At tc. <i>(Sp</i> ec	home, farm, s	street, factory, offi	Се		n (Street end Number or Rural Route Number, Town, Stete)		
	Hospita 4 hours Funeral taly fille	edical C	29a. Certifier 1 CertifyIng Pl	hyalcian: To the besi miner: On the basis and manner s	of examin	owledge, dea ation end/or	ith occurred at the investigation, in m	e time, date end ple ny opinion, death oc	ce, end due to the courred at the time,	ceuse(s) end ma date and placa,	anner as st end due to	tated. the ceuse(s)
	To the Within 2 To the compla	₩.	29b. Signature and title of certifier		1812		29c. Lic	ense number		29d. Date signe	d (Month,	Day, Year)
	⊢ s ⊢ ō		To did to	e (1) A	100	Dan	2 71	82n	0	01-	,	30
•			20 Name and add	Terry !	V	10000	U	100		1/4	7	18
			30. Name and address of person who	completed cause of	death (Iti	23a) (Type	Print)	21/20	1 illock	monto	n	021157
			31. Date filed (Month, Day, Yeer)	Ivagan.	n a trer's Sign	/ C	UAI	COIC NO	VUZ DIV	יווווואין,	///	00113/
	Sta Registr	-	AUG 2 5 1998	Server		4	land	,				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Dey 20, 1998 Neale Augustus 12:10AM August 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Silver Spring Mariner Health Care Montgomery If Under 1 Year 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 8. Dete of Birth (Month, Dey, Year) Months Deys Hours Min. 65 Yrs. 579-48-3893 Oct. 3, 1932 Washington DC Usuel Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2♥ No Fort Washington Maryland Prince George's 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? U.S.A. 20744 2004 Powder Horn Drive 12. Wes Decedent Ever in U.S. Armed Forces? 1 52 Yes 2 □ No 1953— If 4 Fes, Give Yeer or Dates: 1955 Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11. Maritel Stetus Bieck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Postal Service Elementery/Secondary (0-12) N/A College (1-4or 5+) Distribution 18. Mother's Neme (First, Middle, Maiden Sumeme) 17, Fether's Neme (First, Middle, Last) Augusta Neale Otho 19e. Informent's Name/Reletionship (Type, Print) Beverly A. Cox (Wife) 19b. Mailing Address (Street end Number of Rural Route Number, City, or Town, State, Zip Code) 2004 Powder Horn Drive Ft. Washington, MD Aug. 25,1998 20c. Location - City or Town, State Cheltenham, Maryland 20b. Plece of Disposition (Neme of cemetery, crematory or other place) 20e. Method of Disposition Burial 2 Cremetion 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland State Veterans Cem. 21. Signeture of Funeral Service Licensee 22. Name and Address of Fecility Lee Funeral Home, Inc.

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heert feliure. List only one ceuse on each line. **Physician** /Medical Immediete Ceuse (Final diseese or condition resulting In death) **Examiner** Due to (or es e consequence of) Examiner attending physician and for use as the buriel-trensit The law requires that the death certificate be executed Due to (or es e consequence of).

6633 Old Alexandria Ferry Road Clinton, MD 20735 Approximete Intervel Between Onset end Death

mapleto

N/A as 2□ No

1 Yes

Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest

color career

Due to (or es e consequence of):

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? 24a. Was en eutopsy

25. Wes cese referred to medical examiner? 1 Yes 21 No 1 Inpatient 2 ER/Outpetient 3 DOA

26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred

27. Menner of Death 1 Naturel 5 Pending investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 4 ☐ Homicide

28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

1 Tes 2 JAN

(Check only one) 29b. Signature and title of certified

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steted. 2 Medical Examiner: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end manner stated. 29c. License number

009834

29d. Date signed (Month, Dey, Year)

30. Neme end eddress of person who completed cause ol death (Item 23e) (Type, Print)

ROSEMBAUM PARRAGUT AUS. KENSINGTON, MD. BARRY 3720

State Registra

Physician

/Medical

Examiner

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Directo

Funeral

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Certification:

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To the Hospital or Attendir within 24 hours after death.
To the Funerel Director: Af complately filled in by the fu

or Attending Physician:

death.

Funeral

Director

h end Mental Hygiana. 7 ie marked other than "natural", or itema 23a or 28a-f show traumatic event, tra Med cal Examinatinatic confired

Pages 1 and 2 should be filed within 72 hours efter deeth nent of Haalth end Mental Hygiana.
int: If Item 27 ie marked other than "natural", or itema 23.
irty or other traumatic event, tra Madical Examinational

permit. Pages
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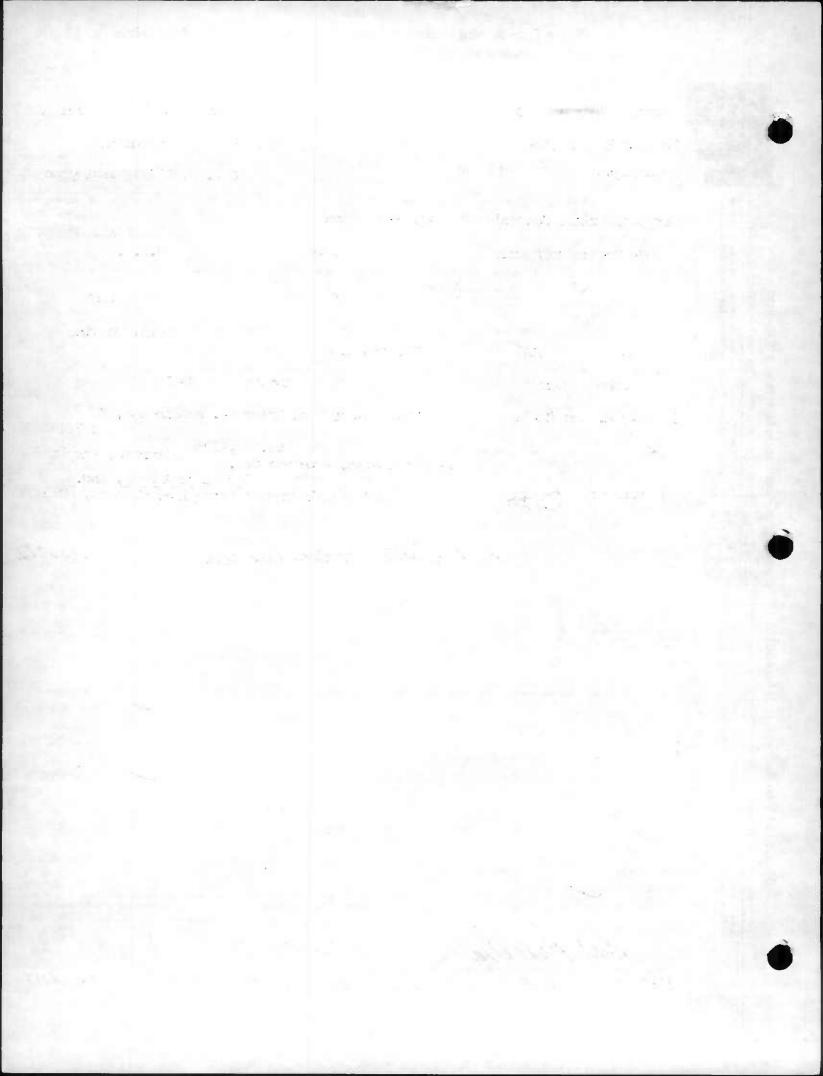
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31. Dete filed (Month, Day, Year) AUG 26 1992 32. Registrer's Signature

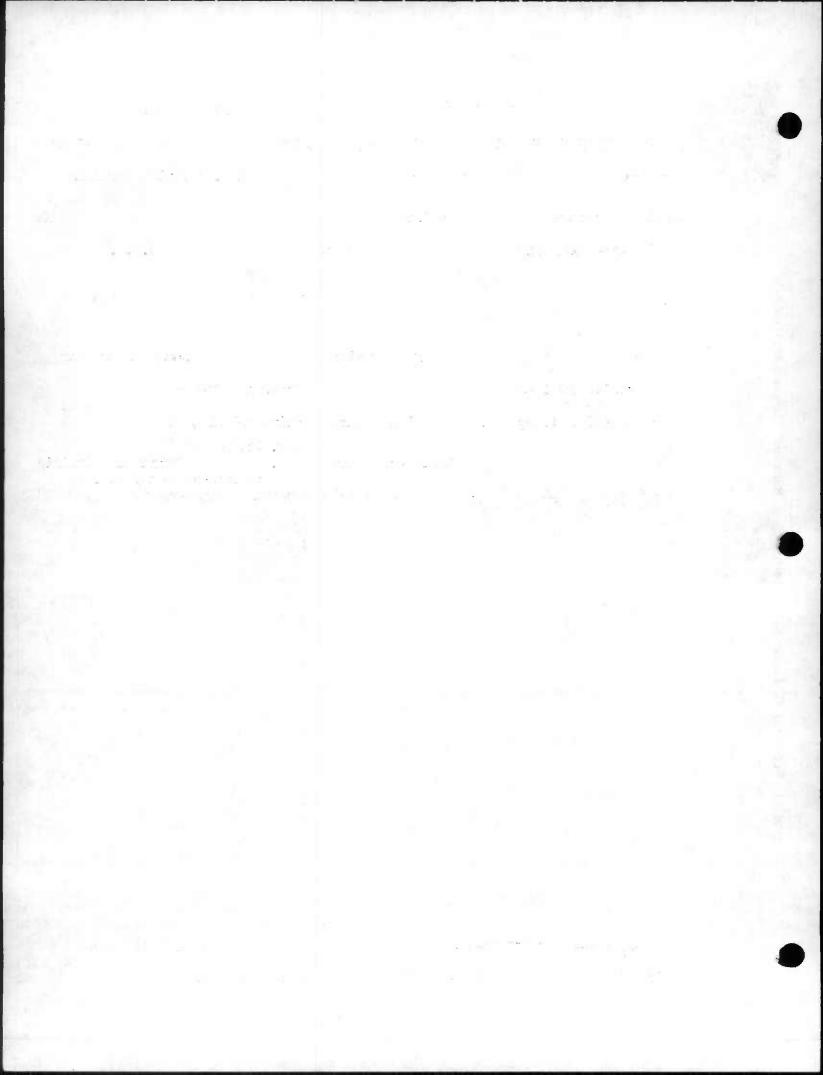
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Division of Vital Records, P.O. Box 68760



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

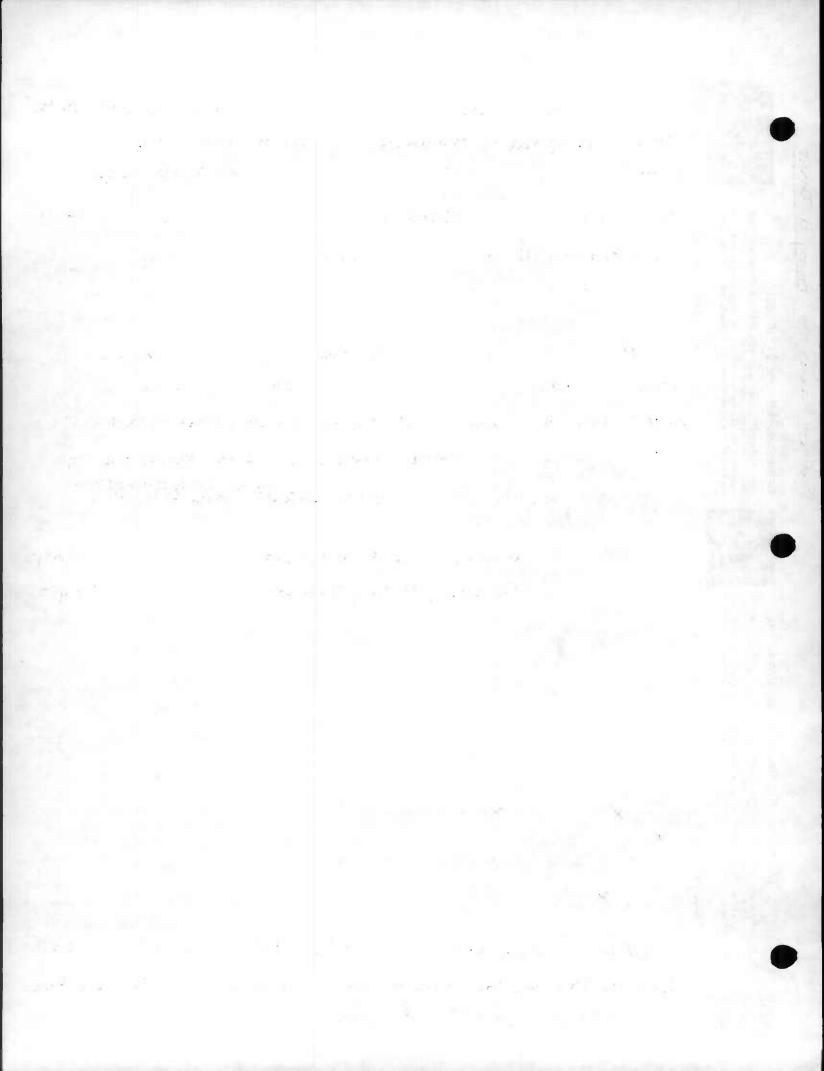
_				State of Ma		Certific				Reg. No.	0 2	1199
П	Physic		Decedent's Name (First, Middle, Last L.O.)	A BELLE CO	OPPAGE				2. Date of De Month	Day	Year	3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution, give	street and number)				4b. City, Town, or		17, 1998 h 4c. County		12:00 NOON
			SOUTHERN MARYLAND	HOSPITAL	CLIN	NTON, M		CLINTON		PRINCE	E GEORG	GES CO.
	Funeral Director		5. Social Security Number 6. S 579-32-1678 Usual Residence of Decedent	DM 20XE	i (In yrs. lest b	Yrs. If U	ths Days	Hours Min.	(Month, Da	th ly, <i>Year)</i> 27 , 1920	9. Birthpiad Country Virgi	e (State or Foreign nia
	yland		10e. Stete 10b. County		10c. City, To	wn or Location					10d	. Inside City Limits
	e Mar Sa-1 st	ctor	Maryland Charles		Wa1	dorf						1 ☐ Yes 2/Q\No
	23e or 2	Funeral Director	10e. Street end Number 2126 Greenwood	Drive		10f	Zip Code 20601			10g. Citizen of V	What Country S.A.	7
020	should be filed within 72 hours after death with the Manyand nd Mental Hyglene. I marked other than "natural", or items 23e or 28e-f show urmatic event, the Medical Exeminet must be notified at	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☒ N if Yes, Give Year or Detes:			ecedent of H specify Cuba s 2\notin No	lispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No to Rican, etc.)		e - American ck, White, etc :: White	
Maryland 21215-0020	hin 72 h	Completed	15. Decedent's Ed (Specify only highest gra- Elementary/Secondary (0-12)	ucation fe com <i>pleted)</i> College (1-4or 5		a. Decedent's (Give kind o life. DO NO	Jsuai Occup f work done T use retired	eation during most of world)	rking	16b. Kind of Bu	usiness/Indus	stry
121	filed wil Hygien ther th		12th	N/A		Book B	nder			Judd &		eiler
anc	should be filed within the Mental Hygiene. marked other than imatic event, the M	Be c	17. Father's Name (First, Middle, Last) Albert Howard	Ponch				18. Mother's Nar			ne)	
ary	2 should and Me is mark raumatic	To	19a. intormant's Name/Relationship (7		19	b. Mailing Add	ress (Street	and Number or Ru	nia Coc	-	Stete. Zip Co	ode)
Σ	Health a em 27 is other trac		Trina Granthan (_		od Drive				
Baltimore,	of He		20a. Method of Disposition ↑ Burlai 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	1	of Disposition ery, crematory		al Cem.	21 , 1998	20c. Location -		, Stete Virginia
Balti	pemit. Pag Department important: ii any injury o		21. Signature of Funeral Service Licen		/	22. Nam	e and Addre	ss of Facility L		al Home	, Inc.	
	Physician		23a. Part1. Enter the disease, or companies shock, or heart tailure. List only of	ications that caused one cause on each lin	the death. Do						A	pproximate terval Between nset and Death
Į.	/Medical Examiner		immediata Cause (Final disease or condition	ARTERIOS	CLEROT	IC CAR	DIOVAS	CULAR DI	SEASE		i	YEARS
	- LAGITITICS	-	resulting in death)	1	Due to (or es a	consequence	of):					
	d d ansit	Examiner	Sequentially list and liting	b	Due to for es a	consequence	of):					
68760,	tificate be executed g physician and as the burial-transit	al Exe	Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c								
	certificate Iding physuse as the	n/Medical	resulting in deeth) Last	d	oue to (or es e	consequence	of):		-			
B	death e atter	Physician/N	Part ii. Other significant conditions co	ntributing to death bu	t not resulting	in the underlyi	na ceuse aiv	en in Part I.	23b. Dfd	tobacco uea coi	ntribute to th	e cause of death?
, P.O	thet the led by th detache		CANCER ESOPHAG	US						Yee 2□ No		oly 4 Unknown
Division of Vital Records, P.O. Box	The law requires thet the death centate has been signed by the attendingage 2 should be detached for use	Completed by	PLEURAL EFFUSI	ON					24a. Was	en autopsy rmed?	evaila	autopsy findings ble prior to ietion of cause ath?
		Соп							10	Yes 2 No	1 🗆 Y	es 2 No
\ <u>\</u>	ician: certific rector	Be	25. Was case referred to medical examiner?	Hospitai:			Oth		ith (Check only o	one)		
lon of	To the Hospital or Attending Physician: Within 24 hours after dealth at 7 the Funerel Director: After this certific completely filled in by the funeral director,	ation: To	1 Yes 2 No 27. Manner of Death 1 Netural 5 Pending 2 Accident Investigation	1 1 Inpatier 28a. Date of Injun (Month, Day	28b.	Time of fnjury M	28c. injun Wor	4 LI Nursing H	ome 5 Resident	dence 6 Oth	1-1-17	
DIVIS	tal or Atterns after december of Director of in by the	Certification:	3 Suicide 6 Could not be determined	28e. Placa of Inju- building, etc.	ry - At home, f (Specify)	erm, street, fac	ctory, office		28f. Location (S City or Tov	Street and Numb vn, State)	er or Rurel R	oute Number,
	Hospi 24 hou Funer Ideley fill	edicai	29a. Certifier 1\overline{\text{Certifying Phy}} (Check only one) 2\overline{\text{Medical Examination}} \text{Medical Examination}	aician: To the best of ner: On the besis of and manner stat	examinetion a	e, death occur nd/or investige	red at the tim tion, in my o	ne, date end piece pinion, deeth occu	, and due to the rred at the time,	cause(s) end me date and place, o	onner as stete and due to th	ed. e cause(s)
	To the Comp	W	29b. Signature and title of certifier				29c. Licens	e number		29d. Date signed	d (Month, Da)	y, Year)
			1/19	24				D-18545		UGUST 1	9, 199	8
			30. Name and eddress of person who c PHILIP WISOTSKY,	M.D. 1207	eth (item 23a) O OLD	(Type, Print) LINE CE	ENTRE	WALDORF,	MD. 206	002		
	Sta Registra	te	31. Date filed (Month, Day, Year) AUG 2 6 19	32. Registrar			home					



Patient Known No! Buby H. Davis

	1. D	ecedent's Ne	me (First, Middle, I	ast)		061	tificate of	Dodin	2. Dete of D Month	Reg. No. eeth Day	Yea	3. Time of	f Death
ysician Iedical	Ru	by	Helen		is				Augur	7 5	1 -	98 19:	45
aminer	4a 1			ive street end number)				4b. City, Town, or I			County of De	eth	
eral	5. S	ociel Security	Number 6			est birthday)	if Under 1 Year	If Under 24 Hrs.		irth	V/A 9. B	intholace (Stete o	or Foreian
		5-86-7		1□ M 2X) F	82	Yrs.	Months Days	Hours Min.	Apr.	ey, Year)	5 Ca	irthplace (Stete o Country) nada	or t or orgin
	Usu	al Residence	of Decedent			Your sale			Trip 2 .	, 1, 1, 1	, , ,		2a . 1 1 - 1a -
70		State	Carrol1		1	r, Town or Lo						10d. Inside C	2 No
	10e	Street and N			LICE	SI SDUI	10f. Zip Code			10a, Citiz	en of Whet	Country?	
i	65	15 Car	rolltowne	Village			21784	4		U.S.	Α.		
Funeral Director	11.	Maritel Status		12. Wes Decedent Armed Forces?	Ever in U,	S. 13. \		Hispenic Origin? (S en, Mexican, Puert	pecify Yes or N			nerican Indien,	
		_	rried 2⊠ Married 4 □ Divorced	1 Yes 2 1 If Yes, Give Year or Detes:			Tes, specify Cub □ Yes 2X No		o ritoan, etc.,			White	
Be Completed		(Spi	15. Decedent's ecify only highest of	Education rade completed)		(Give	lent's Usuel Occup kind of work done	during most of wor	rking	16b. Kir	nd of Busines	s/Industry	
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9	17.		e (First, Middle, La				nomemake1	18. Mother's Nar	me (First, Middle		Sumeme)	iie	
0	Ge	orge	Wen	eley				Ethel		Dav	ris		
	198		Name/Reletionship			19b. Mailir	ng Address (Street	end Number or Ru	ural Route Num	ber, City or	Town, Stete	, Zip Code)	
				Sr./husband	les:			owne Vill		1	-		+
	20a.		2 Cremation 3	☐Removal from State	CE	emetery, crer	sition (Name of natory or other pla		Dete			or Town, State	
	- CA		5 Other (Spec	**	Cres		Memorial G		8/24/98	Marri	ottsvil	le, Maryla	and
	61.	TAL	a Jervice II	prisae				Jet	frey N. Z	unbrur	Funera	l Home	
	231	Part Enter	the disease, or co	policetions that caused	the deeth		~	ille Road E		, ,	land 21	Approximat	te
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Physician/Medica	Test	ulting in deeth) Lasi		,								
5				d								1	
VSIC	Pert	II. Other sign	nificant conditions	contributing to death b	ut not resu	ılting In the u	nderlying ceuse giv	ven in Part I.	23b. Die			ite to the cause	
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eted by										s en eutop tormed?	sy 24	b. Were eutopsy evalleble prior completion of of death?	to
Completed									1	Yes 2	X No	1 Yes 2] No
Be C	25.		erred to medical					26. Place of De					
To B		examiner? 1□ Yes 2戊	No	Hospital:	nt 2	ER/Outpetier	T 3LI DOA	her: 4 Nursing F	lome 5 Re	-	Other (S	pecify)	
		Manner of De	5 Pending	28e. Dete of Inju (Month, De	ry y Year)	28b. Time of Injury	Wo		28d. Deacribe	how injur	y occurred		
Certification:		2 Accident 3 Sulcide	investigat	be on Discontinu	ury a At ha	me form ct-		Yes 2 No	28f. Location	(Street an	d Number or	Rurel Route Nun	nber.
ertif		4 Homicide		d 286. Place of inj building, et			eet, factory, office			own, Stete			
edicai C		. Certifier (Check only		Physician: To the best of aminer: On the besis of									s)
Med		one)	nd title of certifier	end manner sta			29c. Licens	se number		29d Dat	e signed (Mo	onth, Dey, Year)	
	200	1 (Cu	In T	MA alvera	C		Dic	374	,	Am	11-	20 1/1	42.
	30	Neme end ed	dress of person wh	completed cause of d	eeth (Item	23e) (Tyne	Print)	117		Mal	וכעי	0 101	710
		as h	72	Cons. MID	Si	mi Ho	o lation)374 F Baltin	TODE . 2	401 14	Belo	edece A	VF.
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State of Maryland / Department of Health and Mental Hygiene

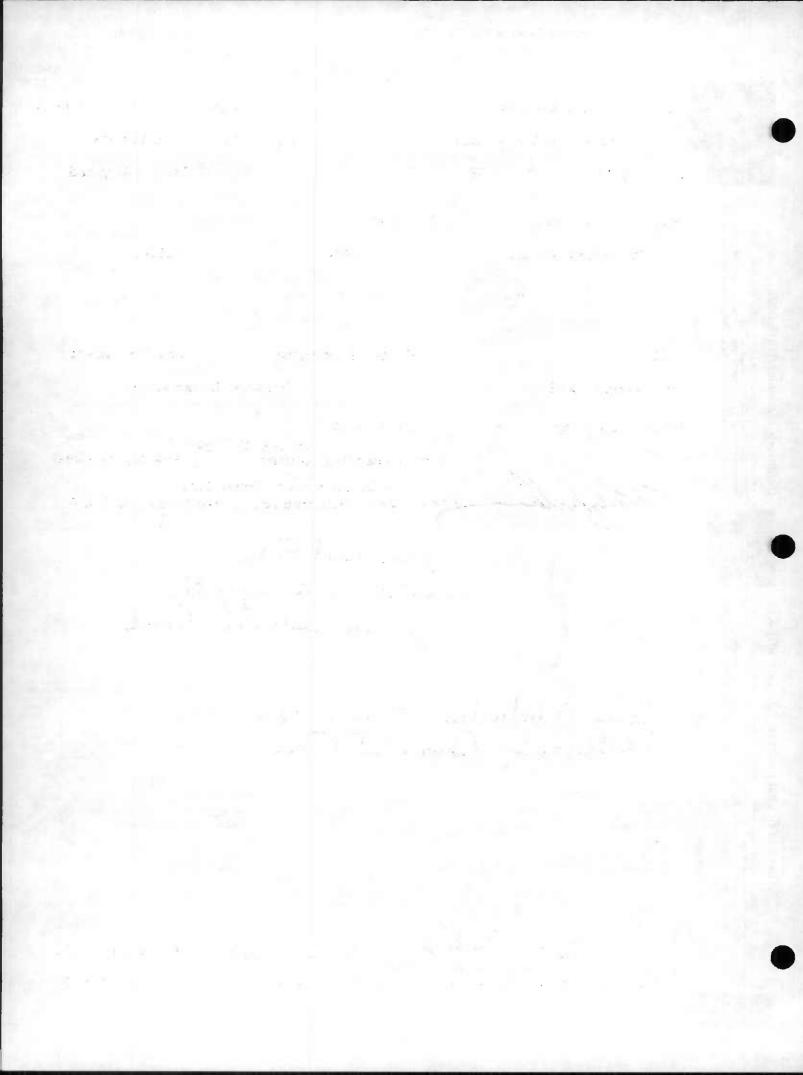
Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3 Time of Death Month Dey **Physician** JOHN ROBERT DORSEY 17, 1998 3:00 pm AUG /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner SYKESVILLE CARROLL 7650 COLLEGE ROAD 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) 8. Date of Birth (Month, Dev. Yeer) **Funeral** 1 → M 2 □ F Months Deys Hours 218-10-4483 79 Yrs. Director 14,1919 Apr MARYLAND Usuel Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at SYKESVILLE 1 ☐ Yes 2X No MARYLAND CARROLL Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? With 21784 7650 COLLEGE ROAD USA Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? 1 XYes 2 □ No If Yes, Give 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indien permit. Peges 1 and 2 should be filed within 72 hours effer to Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or ham any Injury or other traumetral. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: à 3 ☐ Widowed 4 ☑ Divorced Year or Dates: WWII WHITE Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) Elementery/Secondery (0-12) College (1-4or 5+) TRAIN ENGINEER RAILROAD 10 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be HARRY LEE DORSEY SYLVIA DINTERMAN 10 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) ROBERT DORSEY, SON 7650 COLLEGE RD, SYKESVILLE, MD 21784 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 ☐ Burial 2 Cremetion 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) CARROLL CREMATIONS 8/19 HAMPSTEAD, MD 21. Signature of Funerel Service Licensee 22. Name end Address of Fecility ELINE FUNERAL HOME 934 SOUTH MAIN ST, HAMPSTEAD, MD 21074 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Final diseese or condition resulting in deeth) Examiner Due to (or es e consequence of): Examiner Sequentially list conditions, if eny, leeding to Immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initieted events resulting In death) Lest and Due to (or es e consequence of): nding physician ause es the buriel P.O. Box 68760, the death certificate be Physician/Medical Due to (or as e consequence of): atter ò Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? deteched been signed by the should be deteched 2/ No 3 Probably 4 Unknown Records. by 24b. Were eutopsy findings evailable prior to 24e. Wes en eutopsy Completed performed' completion of ceuse of deeth? page 2 No certificate 1 Yes 1 TYes 2 TNo Division of Vital Hospital or Attending Physician: 24 hours efter death. Funeral Director: After this certific 25. Wes cese referred to medicel examiner? Be 26. Plece of Deeth (Check gnly one) Other: 4 Nursing Home Residence 6 Other (Specify) To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Megner of Deeth 28e. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of Certification: 28c. Injury et Work? Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation the 3 Sulcide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) in by 4 Homicide within 24 hours e To the Funeral C 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner as steted.
2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, deeth occurred et the time, date end piece, end due to the ceuse(s) end manner steted. 29e. Certifier Medical To the 29d. Deje signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier 25662 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) GREGORY WALKER MD, 3333 N CALVERT ST, BALTIMORE, MD 21218 31. Dete filed (Month, Dey, Yeer) 32. Registrar's Signature State books AUG 1 9 1998 Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** AUGUST 22 1998 5:00AM ROBEY HENRY DUDLEY, JR /Medical 4a Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 3165 GREEN MEADOWS DRIVE INDIAN HEAD CHARLES If Under 24 Hrs. 8. Dete of Birth (Month, Day, Yeer) If Under 1 Year 5 Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 10X 20 F Months Days Yrs Director 79 June 17,1919 Maryland 214-16-7957 Usuel Residence of Decedent with the Meryland 10e State 10h County 10c. City. Town or Location 10d. toside City Limits 7 is marked other than "natural", or frams 23a or 23a-f show treumatic event, the Madical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Charles Indian Head 10e. Street and Numbe 10f. Zip Code 10g. Citizen of Whet Country? U.S.A. 3165 Green Meadows Dr. 20640 Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? ★□ Yes 2 □ No if Yes, Give Year or Detes: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) permit. Peges 1 and 2 should be filed within 72 hours after a Department of Heelih and Mental Hygiene. Important: If flem 27 is marked other than "natural", or frem any injury or other treumatic event, the Mental Property. Bleck, White, etc. 1 Never Married 2 Married 1 Yes X No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 18b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Planner & Estimator U.S. Government 18 Mother's Name (First Middle Meiden Sumeme) 17. Fether's Name (First, Middle, Last) Be Alice Novella Henderson Roby Hammond Dudley 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Esther M. Dudley Wife Same as #10 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) August 25, Date 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Burial 2 Cremetion 3 Removel from Stete Waldorf, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Trinity Memorial Gardens 22. Name and Address of Facility 21. Signature of Funeral Service License Williams Funeral Home, P.A. M00668 4270 Hawthorne Rd. Indian Head, Md.

23a. Pert1. Enter the 1 sease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart talkin. List only one cause on each line. 20640 Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Final diseese or condition resulting in death) Examiner Examiner Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pue Due to (or es e consequence of) the death certificete be exe physician Box 68760 Due to (or nsequence of): Physician/Medical the 60 USB 23b. Did tobacco use contribute to the causa of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. the signed by t d be detech 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings evelleble prior to Completed 24a. Wes en eutopsy performed? completion of ceuse of deeth? hes page 2 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No certificate or Attending Physician: director 25. Wes case referred to medical Be 28. Place of Deeth (Check only one) exeminer? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA this funeral 28e. Date of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury et Work? After Iniury 1 Detural 5 Pending efter deeth. Director: Aft 1 ☐ Yes 2 ☐ No investigetion 2 Accident 3 Sulcide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 24 hours e Funeral D 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) completely 2 Madicat Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and menner stated. To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Yeer) AUGUST 24, 1998 12000 1009 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) HENRY L. BURKE, MD., 115A LA GRANGE AVENUE, LA PLATA, MD 20646 31. Date filed (Month, Dey, Year) 32. Registrer's Signeture State AUG 26 1998 Registrar

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State of Maryland / Department of Health and Mental Hygiene

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Physicia /Medic Examin	al
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permit. Pagas 1 and 2 should be filed within 72 hours efter death with the Maryla Depertment of Health and Mantal Hygiene. Important: if Itam 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumetic event, it a Medical Examinar rount be notified.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

physician end the burial-trans attending i been signed by the s should be datached certificate director.

Division of Vital Records, P.O. Box 68760, Mospital or Attending Physicism: 24 hours after death. Funeral Director: After this certific funeral filled in by tha To the Hospi within 24 hou To the Funer completely fil

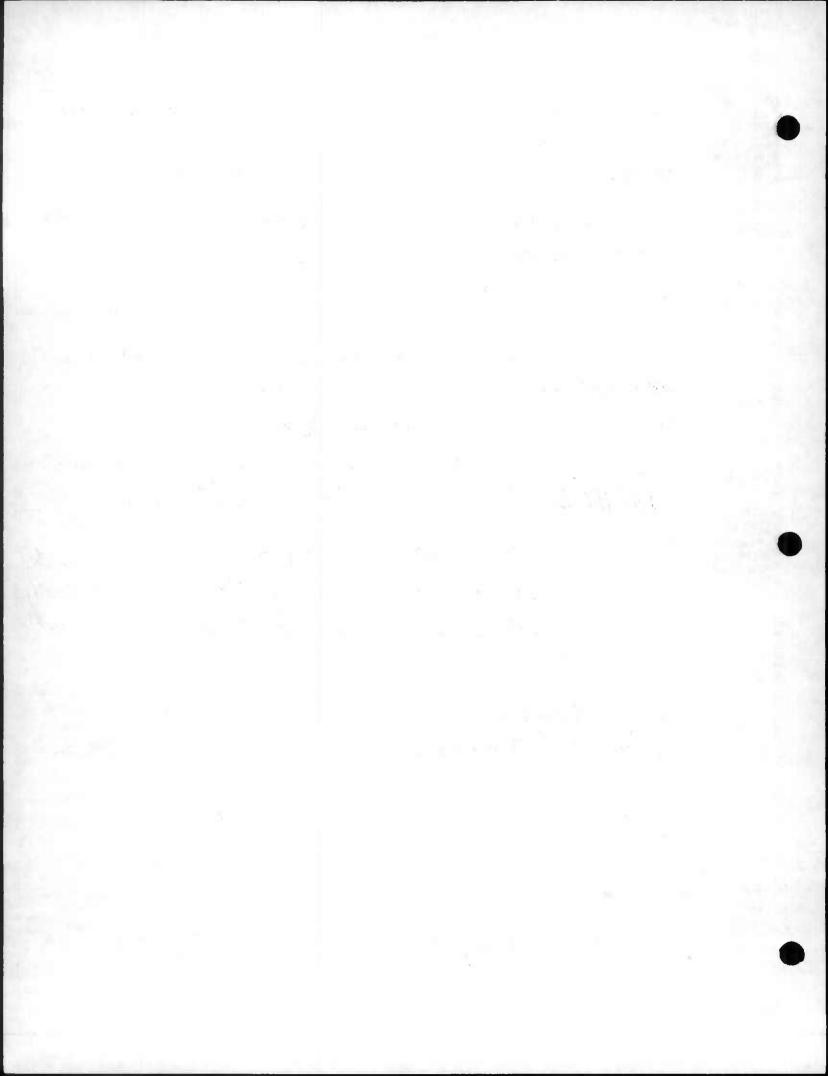
Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Dete of Death 3. Tima of Death Month 1998 **MYRA** LEONE ELIAS AUGUST 9:55 A.M. 4a. Facility Nama (If not Institution, giva street and numbar) 4b. City, Town, or Location of Deeth 4c. County of Deeth 21055 PARK HALL ROAD **BOONSBORO** WASHINGTON If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Yaar) 5. Social Sacurity Number 7. Aga (In yrs. last birthdey) Birthplace (Stata or Foreign Country) 1□ M 2⊠ F Days 399-09-2179 80 Yrs MARCH 6, 1918 WISCONSIN Usual Rasidanca of Dacadant 10e. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2X No Directo MARYLAND WASHINGTON BOONSBORO 10e. Straat end Number 10f. Zip Code 10g. Citizan of What Country? 21055 PARK HALL ROAD 21713 U.S.A. Funerai Was Dacedant of Hispanic Origin? (Specify Yes or No If Yas, specify Cuban, Maxicen, Puerto Rican, etc.) 12. Was Dacedant Evar in U,S. Armed Forcas? 14. Race - Amaricen Indian, Black, Whita, atc. 1 ☐ Yas 2 No If Yas, Giva Year or Datas: 1 ☐ Navar Married 2 ☐ Marriad 1 ☐ Yas 2 🔯 No Spacify: by Specify. 3 Widowed 4 □ Divorced WHITE 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Spacify only highast grada complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE DAY SCHOOL DEPARTMENT HEAD 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) LEOPOLE SCHILLING AGNES MYRUP 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Routa Number, City or Town, Stata, Zip Coda) FUNERAL HOME RECORDS 20b. Placa of Disposition (Nama of cametary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removel from Stata 4 ☐ Donation 5 ☐ Othar (Specify) 8/21/98 SMITHSBURG, MARYLAND SMITHSBURG CREMATORY 21. Signatura of Funaral Sarvice Libansaa 22. Nama end Address of Fecility 7606 Old National Pike Paul M. Dean BAST FUNERAL Home Boonsboro, Maryland 21713 Part1. Enter the disease, or complications that causad tha daath. Do not enter the moda of dylng, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach line. Approximate Interval Between Immediata Cause (Final disease or condition rasulting in daath) Intraceranial Pressure Examiner Sequentially list conditions, if any, laading to immadieta causa. Entar Undarlying Ceuse (Diseasa or injury that initieted events rasulting in death) Last lioblastoma Physician/Medicai Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Wara autopsy findings available prior to complation of ceusa of daath? Completed 24e. Wes en eutopsy 25. Was cesa rafarred to medicel axaminar? Be 26. Place of Death (Check only one) Othar: 4 Nursing Home 5 Rasidence 6 Othar (Specify) 1 Yas 2 No 2 1 ☐ Inpetiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannar of Death 28a. Data of Injury (Month, Day Yaar) 28d. Dascribe how injury occurred 28b. Time of Certification: 28c. Injury at Work? 5 Panding invastigation 1 Netural 1 ☐ Yas 2 ☐ No 2 Accident 3 Suicida 6 Could not ba determined 28f. Location (Straat and Number or Rural Routa Numbar, City or Town, State) 28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledga, daath occurred at tha tima, date end place, and dua to the ceuse(s) end menner as steted.
2 Medical Examinar: On the basis of examination end/or invastigation, in my opinion, daath occurred at tha tima, data and place, and dua to tha ceusa(s) and mannar stated. 29a, Cartifian Medical (Check only one) 29b. Signature end titla of certifiar 29d. Date signed (Month, Dey, Year) 29c. Licansa number 30. Name and address of person tho complated causa of death (Itam 23a) (Type, Print) George E. Way, M.D. 324 E. Antietam Street, Hagerstown, MD 21740 31. Date filed (Month, Day, Year) 32. Registrar's Signatura

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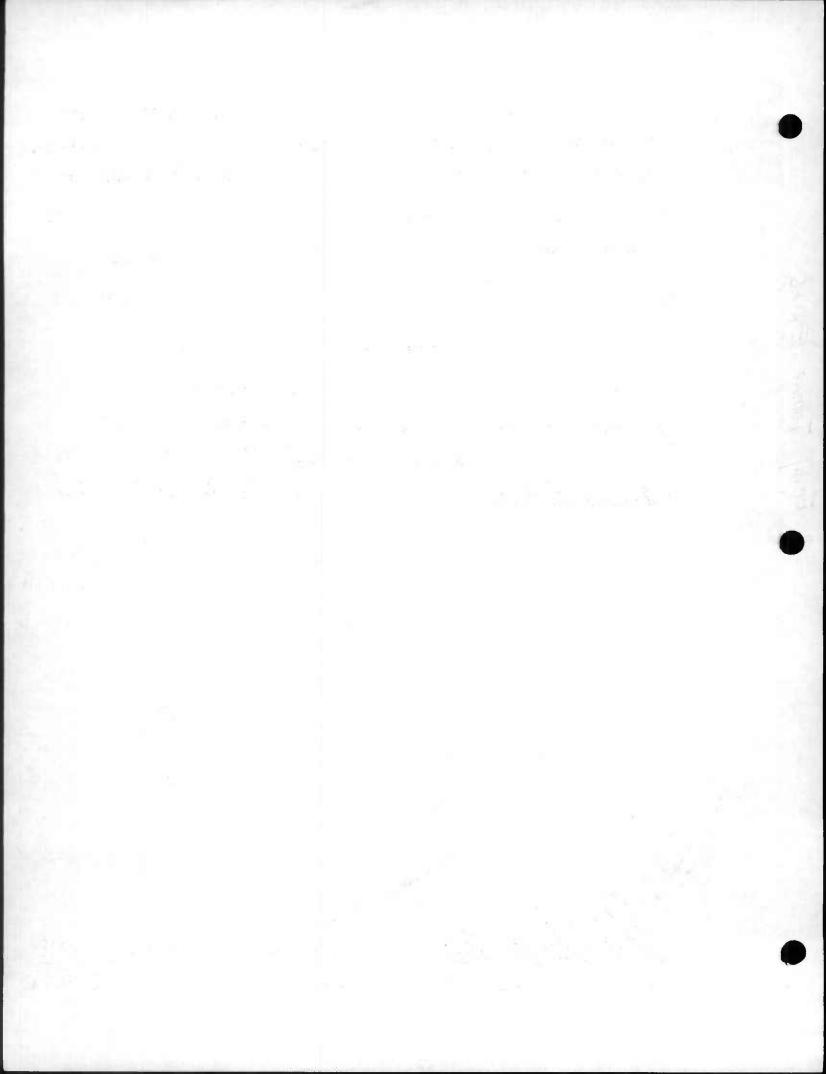
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Registrar

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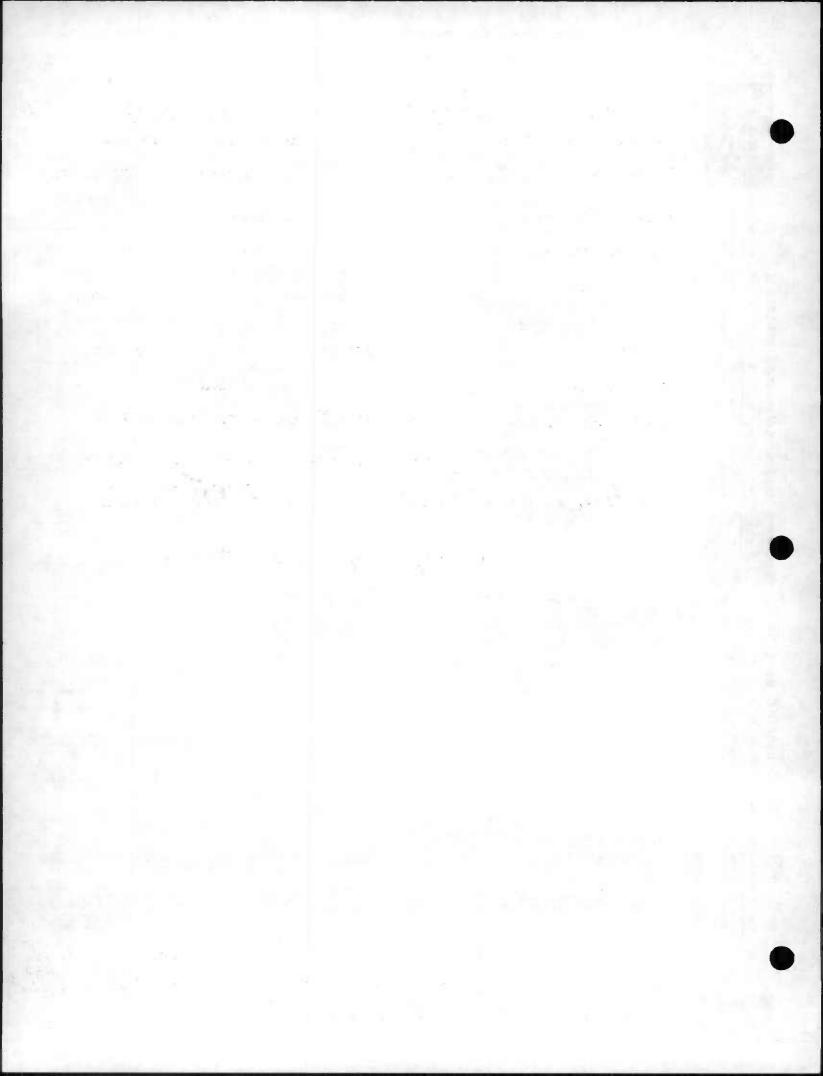


State of Maryland / Department of Health and Mental Hygiene 9

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Physician /Medical	_	Frederio	ck Samuel	GIPE					16, 1998	
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Funeral Director		220-74-0772	Sex 7. Ag	a (In yrs. last bii 63	Yrs. If Under Months	Days	if Undar 24 Hrs. Hours Min.	8. Data of Birth (Month, Dey March 2	Year) , 1935	9. Birthpieca <i>(Stete or Fo</i> Country) Pennsylvani
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Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic esonce.	- 1	19e. informent's Neme/Relationship (end Number or Ru			
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or off	2	20a. Mathod of Disposition 1 ☑ Burlei 2 ☐ Cremation 3 ☐	Removal from State	20b. Pieca o cemete	f Disposition (Ne ry, cremetory or	eme of other plea	xe)	Aug.	20c. Location - C	ity or Town, State
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State of Maryland / Department of Health and Mental Hygiene ?

Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** : 03 4d. County of Death Ohhe 4b. City, Town, or Location of Death /Medical 4a Facility Name (If not institution, give street and number) Examiner BALTIMORE RANDALLSTOWN NORTHWEST HOSPITAL CENTER If Under 1 Yaar 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 F Months Hours Min 161-32-3003 Yrs. 58 MAY 5,1940 PENNSYLVANIA Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location 1 ☐ Yas 2 No BALTIMORE REISTERSTOWN **MARYLAND** Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with than "natural", or items 23s or 21136 USA 316 HIGHFALCON ROAD Pagas 1 and 2 should be filed within 72 hours after death vant of Health and Mental Hygiena. nt: If itam 27 is marked other than "natural", or items 23: Funeral 12. Was Decedant Evar in U,S. Armad Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxicen, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yas 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specity: WHITE p 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOUSEWIFE 7 is marked other traumatic svent, i 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) ESTHER SHUGHART PHILIP KARPER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 316 HIGHFALCON RD, REISTERSTOWN, MD 21136 RODNEY GOBRECHT, HUSBAND other 20b. Placa of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Mathod of Disposition permit. Pagas Department of Important: If it any injury or or 1 ☐ Burial ② ☐ Cremation 3 ☐ Removal from State CARROLL CREMATIONS 8/24 HAMPSTEAD, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servica Licansee 22. Name and Address of Facility ELINE FUNERAL HOME 934 SOUTH MAIN ST, HAMPSTEAD, MD 21074 23a. Part1. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cerdiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Intarval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examine hans and transit the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician a Box 68760 Physician/Medical Due to (or as a consequance of): attending for use as signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No thet Division of Vital Records. p The law requires 24b. Were autopsy findings available prior to should b 24a. Was an autopsy performed? Completed complation of ceusa of deeth? i certificata has t 2 No 1 Yes 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 Thpatient 2 ER/Outpatient 3 DOA this funerai 27. Menner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? 28e. Date of Injury (Month, Day Year) Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death Director: / 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours aft To the Funeral Di complately filled in Hospital 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and pleca, and due to the cause(s) end manner as stated.
2 Description Hedical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and plece, end due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the Within 2 29d. Date signed (Month, Dav. Year) 29b. Signatura and titla of certifiar 29c. License number 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) 2017 hier 3. Registrar's Signature AUG 2 5 1998 Registrar



Maryland 21215-0020

Baltimore.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. Amended Item 20C, 8/31/98 State of Maryland / Department of Health and Mental Hygiene per F.D., Carroll County, wjl Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Deeth Day Month Yaar **Physician** RYAN LYNN GLISSON AUGUST 17, 1998 2339PM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) Examiner BUTLER 14921 FALLS ROAD AND WESTERN RUN ROAD BALTIMORE COUNTY 8. Dete of Birth (Month, Day, Year) FEB 6, 1977 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthday) **Funeral** 1X M 2 □ F Months Deys Hours 215-88-5379 21 MARYLAND Director Usual Residence of Deceden filed within 72 hours after death with the Maryland 10d. inside City Limits r 28a-f show 10a State 10h Counts 10c. City. Town or Location 1 Yas 2 No MARYLAND CARROLL HAMPSTEAD Director 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Code mast be r 21074 1208 WOODLAND COURT USA B 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Funer than "natural", or items the Medical Examiner m 14. Race - American Indian, 11. Marital Status 12. Was Decedent Evar in U,S. Armed Forcas? Black White etc. 1 Yes 2 No if Yes, Give Yaar or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Specify: WHITE by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Giva kind of work dona during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) COMPUTER COMPUTER TECHNICIAN 12 other 7 is marked other 18. Mother's Name (First, Middle, Meiden Surneme) 17. Fathar's Name (First, Middle, Last) Be Pages 1 and 2 should be f nent of Health and Mental F nt: If item 27 is marked ot BARBARA RIDENOUR LYNN GLISSON 19b. Mailing Addrass (Street end Number or Rurel Route Number, City or Town, State, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) LYNN GLISSON, FATHER 1208 WOODLAND COURT, HAMPSTEAD, MD 21074 other 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) WHITE HALL, MD Department c important: If i any injury or BETHEL PRESBYTERIAN CEM 8/21 COMPUTER COMPANY 22. Name end Addrass of Facility 21. Signature of Fuperal Sarvice Licensae ELINE FUNERAL HOME 934 SOUTH MAIN ST, HAMPSTEAD, MD 21074 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haert failure. List only one cause on each line. Approximete Interval Batween Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Multiple Injuries Examiner Due to (or es e consequença of) Examiner that the death certificate be executed physician and s the burial-transit Sequentially list conditions, if any, laading to immediata causa. Enter Underlying Causa (Disease or Injury that initiated evants resulting in death) Last Due to (or as e consequence of): Physician/Medical Due to (or as e consequance of) ettending pt 23b. Did tobacco usa contribute to the causa of death? signed by the e Pert II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Pert I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown þ The law requires 24b. Ware autopsy findings available prior to complation of cause of death? been si 24e. Was en eutopsy Completed performed' certificate hes t irector, page 2 s 17 Yes 2 No 1⊠ Yes 2□ No Physician: director, 25. Was case referred to medical examiner? 26. Place of Daath (Check only ona) Be Other: 4 Nursing Homa 5 Residence 6 KlOthar (Specify)ROADWAY 1⊠ Yes 2□ No 10 1 ☐ Inpatient 2 ☐ ER/Outpatienf 3 ☐ DOA this funeral Driver of motor rehicle went 28a. Data of Injury (Wonth, Day Year) 28b. Tima of 27. Menner of Death 28c. Injury at Work? Certification: Attending 1 Natural 5 ☐ Panding 281. Location (Street and Number or Rurel Route Number, City or Town, State) 1 Yes 2 No death. 17/98 investigation 2 X Accident Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

ad - Falls Rd and h 6 Could not be datarmined 3 ☐ Sulcide 28a. 4 | Homicida Western Run

Box 68760, o Division of Vital Records, ector: Direc 24 hours after Funeral Dire letaly filled in b ŏ To the within 2.
To the f

31. Date filed (Month, Dey, Year) State Registrar

Medical

29a. Cartifiar

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Itam 23a) (Type, Print) Joseph Pestaner, M.D.

AUG 1 9 1998

32. Ragistrar's Signature

111 Penn Street, Baltimore, Maryland 21201 oaks

1 Cartifying Physician: To the best of my knowledge, daath occurred at the time, date end placa, end due to the cause(s) and mannar as stated.

2 Medicat Examinar: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and placa, and due to the ceuse(s) and mannar stated.

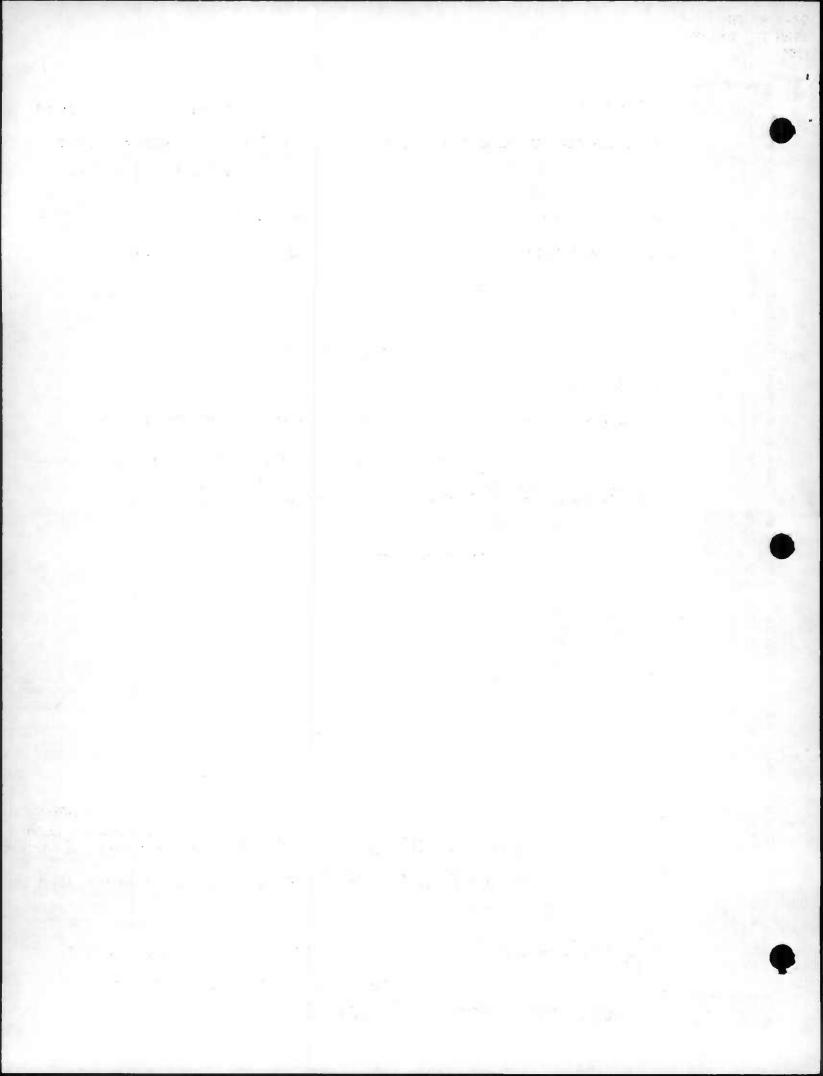
29c. License number

O.C.M.E.

Baltimore, Md

29d. Date signed (Month, Day, Year)

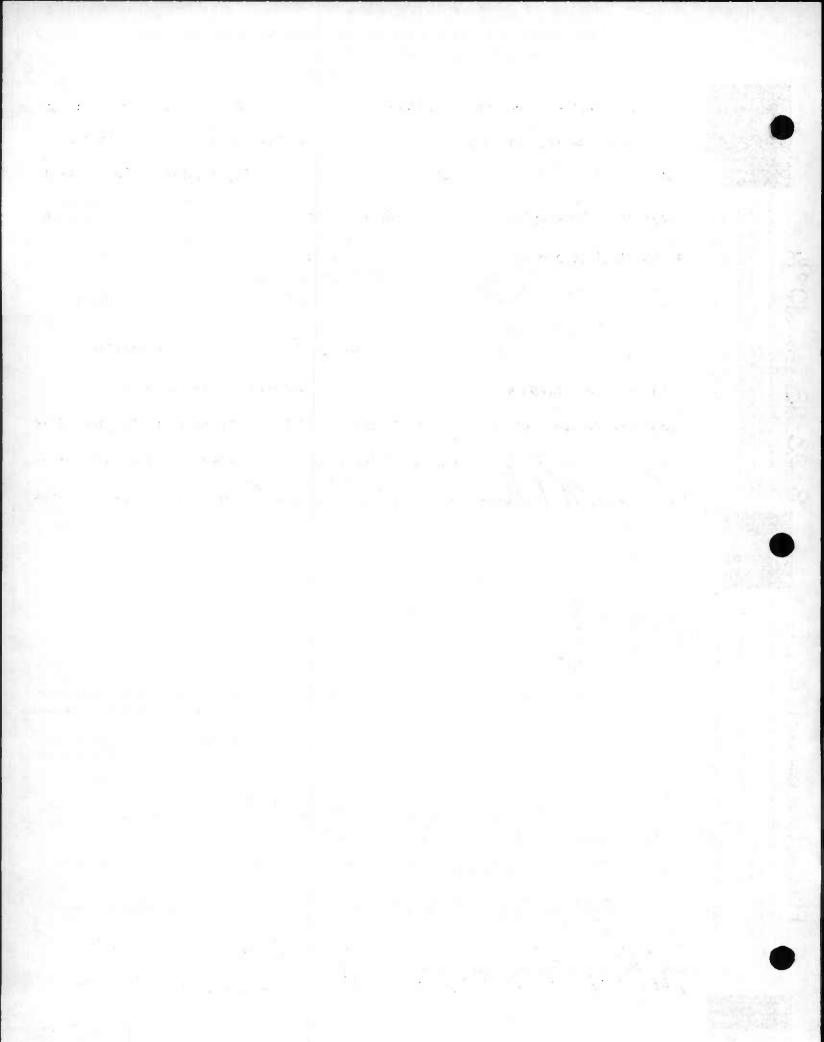
AUGUST 18, 1998



State of Maryland / Department of Health and Mental Hygiene

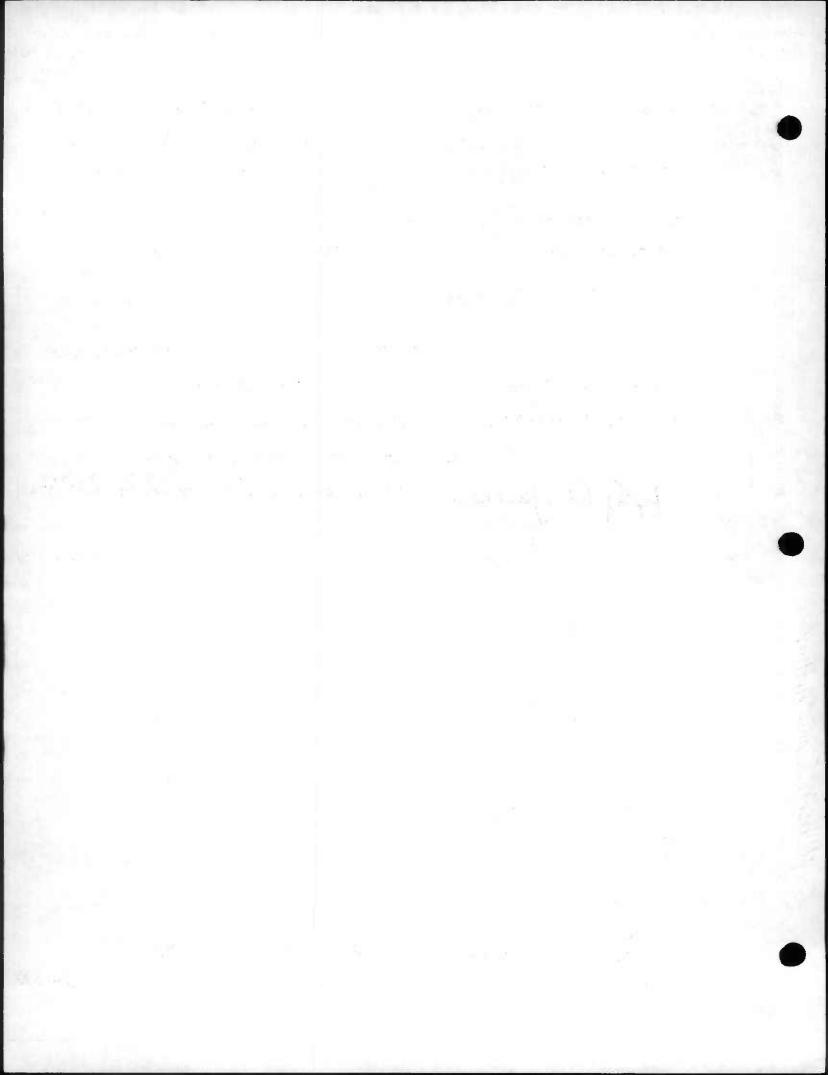
27208

						Cei	tificate c	of Death		Reg. No.		- 1 - 00
	Physic /Medi		1. Decedent's Nama (First, Middla, Glenn Willia		on Hump	hreys	5		2. Dete of De Augus	eth	1998	3. Tima of Death 10:30 am
	Exami		4e. Facility Nema (If not Institution, Homewood Ret	rement Ce				4b. City, Town, or Willia			of Death	gton
	Funeral Director		5. Sociel Security Number 084-26-9385 Usuel Rasidence of Decedant	3. Sex 7 1 ☑ M 2 ☐ F	. Aga (In yrs. la:	st birthdey) Yrs.	If Under 1 Ye Months De			, 1914	9. Birthpi Count Penn	ace (Steta or Foreign try) Sylvania
	death with the Maryland me 23e or 28e-f show	ctor	10a. Stata 10b. County	nington	10c. City,	Town or Lo	cation /illiams	sport			10	Od. Insida City Limits
. <	with th	Dire	10e. Street and Number 16505 Virginia	Avanua			10f. Zip Cod	1795		10g. Citizan of	What Count	
1030/	urs after death al', or items 23	by Funeral Director	11. Marital Status 1 Nevar Merried 2 Marrie 3 Wildowed 4 Divorced	12. Was Daced Armed Ford				of Hispanic Origin? (S uban, Maxicen, Puan	pacify Yes or No to Ricen, etc.)	o- 14. Rac Bla Specif	ce - America ck, Whita, a	an Indien,
21215-0	d within 72 ho piena. r than "natur r Mad cal	Be Completed	15. Decedent's (Specify only highast Elamantary/Secondary (0-12)	Education grada complated) Collaga (1-4		16a. Deced (Giva lifa. L	dant's Usual Oct kind of work do. DO NOT usa ret Profess	na during most of wo ired)	rking	16b. Kind of B	usinass/ind	·
Syland	ould be file Mental Hyg arked othe atic event,	To Be C		Humphreys				18. Mother's Nar				
8 - 32 - 98 C Baltimore, Maryland 21215-0020	permit. Pagas 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglena. Important: if item 27 is marked other than "natural", or items 23e or 28e4 show any lojury or other traumatic event, or Medical Empirical Living to notice any logue.		Mary Anne Burke, 20a. Mathod of Disposition 1	Daughter	tata cen	13226 ce of Dispo natery, cran e Hill	Briand sition (Nama of natory or other) Cemete Nama and Ad Sborne	olace)	e Hage Data 8-26-98 me	rstown, 20c. Location Hagers	Mary I City or Tow Stown,	and 21740 wm, Stata Maryland
∩ ∩ Box 68760,	Physician percented by the confliction of the confl	an/Medical Examiner	Enter the diseasa, or or shock, or heart feitura. List or Immediata Cause (Finel diseasa or condition resulting in death) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseasa or Injury that initiated events resulting in death) Last		Due to (or e	es a conseques a conseque	juance of):	nying, such es cerdial	c or raspiratory a	irrest,		Approximete Interval Between Onsat and Death
Gler 1s, P.O. B	requiras that tha daath seen signed by tha atter hould be dateched for u	by Physician	Part II. Other significant conditions	a contributing to dea		ing in tha ur	ndariying ceusa	givan In Part I.		tobacco use co		the cauea of death?
Second	2 S S	Completed							24a. Was peri	an autopsy ormed?	ava	ra autopsy findings ilable prior to npletion of ceusa leath?
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of V	Physical this car	2	axaminar? 1 ☐ Yas 2 No	Hospital: 1 🗆 Inj		R/Outpetien	t 3LI DOA			ldanca 6 □Ott		')
A de lision	Aftar funar	Certification:	27. Mennar of Daath 1 Natural 5 Pending 2 Accidant invastigat 3 Sulcide 6 Could no	be one Blasse	Day Year) 2	8b. Tima of injury	M 1	njury at Vork? ☐ Yas 2 ☐ No		how injury occur		Doute Number
片	rs after at Direct	Certi	4 ☐ Homicida detarmin	building	, etc. (Specify)	a, rami, sur	sat, raciory, oni		City or To	wn, Stata)	or or ribrar	riodia rambor,
土	To the Hospital or Attent within 24 hours after deat To the Funeral Director: completely filled in by the	Medical	29a. Cartifiar (Check only one) 19b. Signature appropriate to confine	Physician: To the basaminar: On the bas end manna	is of examinetion	edga, daeth n and/or inv	astigation, In m	time, deta end place y opinion, death occu	, and dua to the irred at the time	data and plece,	and dua to	tha ceuse(s)
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			Alro) 16N	o complated ceusa	No	Han	Print) AL	e Hy	9 New	, Mo	217	42
	Sta Registr		31. Data filed (Month, Dey, Year) AUG 2 4 1998	32. He	glstrer's Signatu	1. 14	parks	/				



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** Month 4b. City, Town, or Location of Deeth 0526am Joseph Arthur Hillebert, Sr. /Medical 4e. Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Washing ton Washington County Hospital Hagerstown If Under 24 Hrs. 8. Dete of Birth (Month, Day, Dec. 28) If Under 1 Yeer 5. Social Security Number 9. Birthplace (State or Foreign Country) New York 7. Age (In yrs. lest birthdey) **Funeral** Year) 1915 Months Deys 1 XM 2 □ F 579-10-9117 82 Yrs Dec. Director Usuel Rasidence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinar must be notified at Washington 1 Tyes 2 X No Directo Maryland Hagerstown 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 6 Princeton Place 21742 U.S.A. Funeral 72 hours after death 12. Was Decedent Ever In U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bieck, White, etc. 1 Never Married 2 Married 1 DYes 2 No If Yas, Give 1942-45 Yeer or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retirad) 16b. Kind of Business/Industry filed within 7 I Hygiene. Elementary/Secondery (0-12) Coilege (1-4or 5+) permit. Peges 1 end 2 should be filled wi Depertment of Health and Mental Hygien Important: If Ilem 27 Is marked other thy any injury or other traumatic event, the once. Chauffeur Church Missionaries 17. Fethar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Be Chester Arthur Hillebert Rita Maude Jack 19e. Informent's Neme/Raletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Coda) Mildred V. Hillebert/Wife 6 Princeton Place, Hagerstown, Maryland 21742 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State Cedar Lawn Memorial Park Aug. 24 Hagerstown, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility Douglas A. Fiery Funeral Home 331 Eastern Blvd. N., Hagerstown, Maryland 21742 UL 23e. Per H. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediata Cause (Finel diseese or condition resulting in deeth) ADVANCED BLAPDER CANGER LOCALLY Examiner Due to (or es e consequenca of): Examiner physician and the buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Completed by Physician/Medical Due to (or es e consequence of): for use es ed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Unknown AIMONUSAG 24b. Were autopsy findings evellable prior to completion of causa of daath? 24a. Was en eutopsy performed? pege 2 s certificate 1 Yes 20 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Wes case raferred to medical examiner? Be 26. Plece of Death (Check only ona) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes ≥ No Certification: To 2 ER/Outpatient 3 DOA this 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28h Time of 28d. Describe how injury occurred 28c. injury et Work? After 5 Pending Invastigation Naturel 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident Director: / 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) within 24 hours efter d To the Funeral Direct completely filled in by 4 Homicide ō 29a. Certifier edicai Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and menner as stated. (Check only one) 2 Medical Examinar: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) and menner stated. To the within 2. 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) west D444 + eddrass of person who complated causa of daath (Itam 23e) (Type, Print) 11110 MEDICAL CAMPUS DRIVE SOME LOC WEST 31. Deta filed (Month, Day, Year) AUG 2 1 7 32. Registrer's Signeture State Registrar

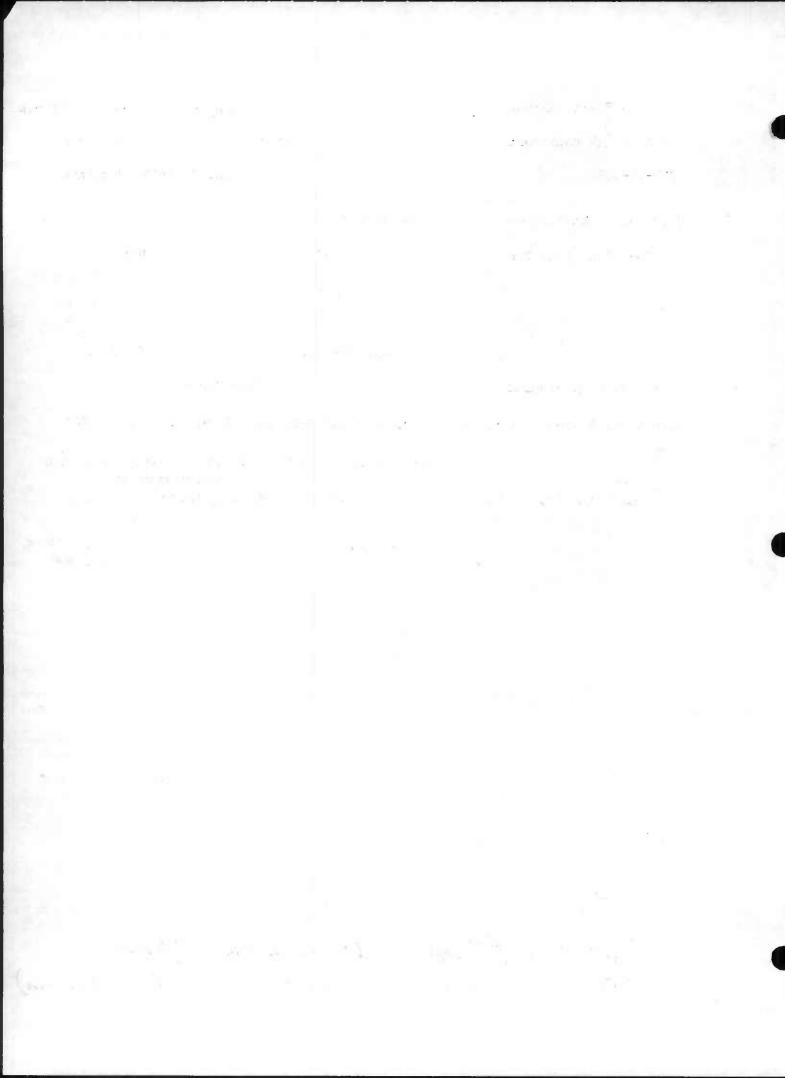


State of Maryland / Department of Health and Mental Hygie

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						Ce	rtificate	of	Death			Reg. No.	-	16.10
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	/Medic		Richard Irvin	HAMMOND							Augus		998	10:53 a.m
E	Examir		4a. Facility Name (If not institution 21704 Black Ro	The state of the s	umber)			4	Hage		ocation of Deal			ngton
	uneral rector		5. Social Security Number 220–16–0053	6. Sax 1⊈M 2□ F	7. Aga (In yrs. 85	last birthday) Yrs.	If Under 1 Months I	Yaer Days	if Undar Hours	24 Hrs. Min.	8. Dete of Bi (Month, Di Feb.	oy, Year) 8, 1913	Cour	piaca (Stata or Foraign http:/ yland
Ď	57		Usual Residence of Decedent											
Marylar	af show	tor	Maryland Was	nington	10c. Cit	ty, Town or Li Hage	ocation erstown	i					1	0d. Inside City Limits 1 ☐ Yas 2 ☑ No
with the	3a or 28 at be no	Funeral Director	10e. Street and Number 21704 Black R	ock Road			10f. Zip C		740			10g. Citizan of U	What Cour	ntry?
Jeat	2 8 2	era	11. Maritai Status	12. Was Dad	sedent Ever in U	l,S. 13.	Was Decedar	t of H	lispanic Orig	gin? (Sp	ecify Yas or N Rican, etc.)	o- 14. Rac	e - Americ	can Indian,
72 hours after death with the Maryland	important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumstic event, the Medical Examiner rivals be notified at once.	by	1 ☐ Never Married 2 ☐ Marri 3X Widowed 4 ☐ Divorced	Armed F ed 1 Tes If Yes, G Yaer or I	2⊠No iva		if Yes, specify			, Puarto	Rican, etc.)	Specify	ck, White,	white
72 hc	ar ar	ted	15. Decedent (Specify only highes	a Education	1	16a. Dece	dent's Usual (Occup	ation	of work	ina	16b. Kind of B	usiness/in	dustry
filed within 72 hours af Hygiene.	The Med	Completed	Elementary/Secondary (0-12)	1	(1-4or 5+)		kind of work DO NOT use shop fo			OI WORK	n g	ind	ustri	ial
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d 2 should be file th and Mental Hy	Is mari	To	19e. informent's Name/Reletionsh		1.							per, City or Town,		
1 end Heelth	m 27 her t		Barbara L. Hamm	ond - dat					ROCK	Rd.		cstown,		
Peges nent of h	ant: If its ury or of		20a. Method of Disposition 1 ☑ Buriai 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp			cemetery, cre	osition (Neme metory or othe Haven	r pled	•	8-	Dete -24-98	20c. Location	1	own, State Maryland
permit. Peges 1 er	any Inju		21. Signature of Funeral Service L	icensee	muse	1	2. Name and					CH FUNE		
_			23a. Pert1. Enter tha disaase, or shock, or haart failure. List of	complications that	caused the deat	1								Approximete
Phys	sician		shock, or haart failure. List o	nly ona ceusa on	each line.						,		į	Interval Batween Onset and Death
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requires that the	5.8	d by					v				24a. Was	an autopsy	24b. W	are autopsy findings
₩ N	hes been s ye 2 should	Completed			-50						perf	ormed?	av	allable prior to mpletion of cause death?
F	pag	S									1 🗆	Yes 2 No	10	Yes 22 No
cian	s certificate director, pag	Be	25. Was case referred to medical examiner?	Magnital				011		of Deet	n (Check only	one)		
	O S	2	1 Yes 2 No			ER/Outpatie		Oth	4 🗀 140			dance 8 DOth		(y)
ling F		lon	27. Mannar of Death 1 ☐ Natural 5 ☐ Pending		of Injury oth, Dey Year)	28b. Tima o tnjury		Wor			28d. Describe	how injury occur	red	
Attending or death.	the	cat	2 Accident Investig 3 Suicida 8 Could n	ot be	4.1.		М		Yes 2 1		OR Leasting	(Chanadan of Shami	na a Dua	I Barta Marahas
tal or Attending rs efter death.	af Direc led in by	Certification:	4 ☐ Homicide determine	ned 28e. Place build	e of Injury - At he ling, etc. <i>(Specif</i>	y)	raet, factory, o	TICE				(Street end Numi wn, Stete)	er or nura	il Houte Number,
To the Hospital or within 24 hours efter	To the Funeral Director: After completely filled in by the fune	edical	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the xaminar: On the b and mer	e best of my kno pasis of axamine oner stated.	wiedge, deet tion and/or in	h occurred et vestigetion, In	the tin	ne, dete and pinion, deel	d place, th occurr	and due to the ed et the tima,	cause(s) and modele and place,	ennar as s and dua to	tated. the cause(s)
vithir	To th	M	29b. Signature and title of certifier	1//	× -		29c. L	icens	e number			29d. Deta signe	d (Month,	Day, Year)
		İ	> Vment A	Caron	J me	0	Do	0 5	036.	2 ,	mD	8/24/	18	
			30. Nama and address of person v		se of death (Item Son; ±4s		Print)	2	1783	(1	Cinco-	t A.	0	tore mo
	Sta	te	31. Data filed (Month, Dev. Year)	32/1	Registrar's Signa			-	1703	("	INCEN	- /	-49	1072 -00
F	Registr	ar	AUG 2 5 19	38	neva	B.	Local	1	/					

DHMH 16 Rav 6/95



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Jours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1. 2. 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYLAN		MENT OF HE		ENTAL HYGIEN		The I have I I
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH		3. TIME OF DEATH
	VIOLA MARIE HOF	FMAN				duy, 1	3,1998 YEAR	2:55 am
	4. SOCIAL SECURITY NUMBER				7	7. DATE OF BIRTH (Month, Day, Year)	8. BIRT	HPLACE (State or Foreign
	156-20-1153 9a. FACILITY NAME (If not institution, give	1 M 2 X F	81 YRS.		OURS MIN.	Jan. 27, 19		nigan
TOR	Continium Care			Sykesvi			Carro	
DIRECTOR	10e. STATE 10b. COUN	Carroll	1000	own or LOCATIO	1			10d. INSIDE CITY LIMITS?
	10e. STREET AND NUMBER		, MCDO		P CODE		100 CITIZEN OF	1 YES 2 NO WHAT COUNTRY?
ER.	102 Timber Ridge	Drive, Apt. 21	2	,,,,,	21157			States
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVER IN U	S. ARMED	13. WAS DECEN	DENT OF HISPANIC	ORIGIN? (Specify Ye	s or No- 14. RAG	CE — American Indian,
BY F	1 Never Married 2 Married 3 🔀 Widowed 4 Divorced	FORCES? 1 TYES IF YES, GIVE WAR OR DATE			y Cuban, Maxican, NO Specify:	Puerto Rican, atc.)	810	ck, White, etc. city: White
ED B	15. DECEDENT'S ED	HICATION				1		white
ETE	(Specify only highest grad	de completed)	(Give kind of work the, Do NOT use re	done during most	f working	16b. KIND OF BU	SINESS/INDUSTRY	
PLE	Elementary/Secondary (0-12)	College (1-4 or 5+)	Seamstr	cess		Sewino	1	
COMPLET	17. FATHER'S NAME (First, Middle, Last)			1	. MOTHER'S NAME	(First, Middle, Maiden		
BE (Angus Henry Char	ron				manda Mer		
0	19a. INFORMANT'S NAME (Type/Print)	ou /douglet				ute Number, City or Tox		=0.
	Doris Cartzendafn					ion Bridg		
	1 Buriel 2 Cremation 3 Re 4 Donation S Other (Specify)	moval from State 20b. Pl	ACEAND DATE OF DECRETOR OF CONTROL OF CONTRO	place)	y 8/20/		pstead,	
	21. SIGNATURE OF FUNERAL SERVICE L		Jairour C		ADDRESS OF FACIL		llis Str	
	Kennifer	J. Oche	n	Myers	Funeral			MD 21157
	23. PART /. Enter the diseases, or shock, or heart failure	complications that caused to List only one cause on each	ne deeth. Do not	enter the mode	of dying, such	ea cerdiac or reap	iratory arrest,	Approximate
	IMMEDIATE CAUSE (Final	A Miles and the second		1	11			Interval Between Onset and Daath
	disease or condition resulting in death)	Non- Ha		3 M	myer	mer		
		DUE TO (OR AS A C	ONSEQUENCE OF):	Sho	De 17.			
ION	Sequentially list conditions, if any, leading to immediate	b. DUIL TO (OR AS A CO	ONSEQUENCE OF):	1.00	8-			
CAT	cause. Enter UNDERLYING CAUSE (Disease or Injury	· Candi	Liarsis	oes	Mey	itis.		
E	that initiated events	DUE TO (OR AS A CO	ONSEQUENCE OF):	^	1			
CERTIFICATION	resulting in death) LAST	a Delyda	elin	10	mg 1'-1) wit	Ac.	
AL C	PART ii. Other algnificent condition		not reauiting in t	the underlying o	ause given in Pa	ert f. 24s. WAS AN		b. WERE AUTOPSY FINDINGS
DIC	1/2/whyc	unition				PERFO		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
ME		American in the second						1 YES 2 NO
PHYSICIAN: MEDIC								
2	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	0	26. PLAC	E OF DEATH (Check	k only one)		
ΙΥS	1 🗍 YES 2 🖟 NO 27. MANNER OF DEATH	1 Inpetient 2 ER/Outpetie		Nursing Home	5 Residence 6			- Harris III
	1 Natural 5 Pending	(Month, Day, Year)	INJURY	Y WORK	2 NO	ed. OESCRIBE HOW	INJURY OCCURED	
ВУ	2 Accident Investigation 3 Suicide & Could and by	28e. PLACE OF INJURY —	At home, ferm, stree			81. LOCATION (Street	end Number or Rural	Route Number
Ī	4 Homicide 6 Could not be determined	building, atc. (Specify)				City or Town, State		
COMPLETED	29a. CERTIFIER 1 CERTIFYING PHY	SICIAN: To the bast of my knowled	ge, death occurred a	it the time, deta an	d place, and due to	the cause(s) and ma	nner en steted.	
OM		NER: On the basis of examination a						(s) end manner as stated.
ш	29b SIGNATURE AND TITLE OF CERTIFI	ER ()		2	C. LICENSE NUMB	ER	29d. DATE SIGNE	O (Month, Day, Year)
00	Bleenda	sidning,			30110	1	18-10	7-98
5	30. NAME AND ADDRESS OF PERSON W	CECUTILE	(ITEM 27) (Type, Pri	d f	Kesr	ille	2178	24
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATI	JRE 4	1	10-31			7
	AUG 1 9 199	8 perent	P. A	parks				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 5:15 Month torman Mabre 4b. City, Town, or Location of Death 4e. Facility Nama (If not institution, giva street and number) 4c. County of Death Nursing (DUNT irhaven taci if Uniter 24 Hrs. arro If Under 1 Yaar Months Days 7. Apa (In yrs. last birthday) 5. Social Security Number 6. Sax 8. Date of Birth (Month, Dey, Year) Birthpleca (Stete or Foraig Country) 217-07-6915 1 M 2 F Days Hours 82 29, 1915 Maryland Usuai Rasidanca of Dacedant 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Carroll Sykesville TV Yas 2 No 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 7200 Third Avenue 21784 U.S.A. 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2♥ No If Yes, Giva² Year or Dates: 11. Maritei Status Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. Raca - Amarican Indian, Black, White, etc. 1 ☐ Never Married 2 【文 Married 1 Yas 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highast grade completed) Elemantary/Secondery (0-12) Coilege (1-4or 5+) Registered Nurse Health Care 17. Father's Neme (First, Middle, Last) 18. Mothar's Nama (First, Middle, Meiden Sumeme) Leroy Walker Gabriella Sodler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, State, Zip Code) 7200 Third Avenue Sykesville, MD 21784 20b. Place of Disposition (Neme of cematery, crematory or other place) 20c. Location - City or Town, State Mr. Earle Horman (Husband) 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Harmony Cemetery 8/19/98 West Friendship, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Servica Licenses 22. Name end Address of Fecility HAIGHT FUNERAL HOME & CAHPEL (Box 195) Maight 23a. Pert1. Enter the diseasa, or complications that decised the death. Do not enter the mode of dying, such as ca shock, or heart failure. List only one cause on each line. 21784 (410) - 795 - 1400 Indiac or respiratory errest. Approximete Interval Between Onset end Death Monte immediate Cause (Final porration disease or condition rasulting in death) ears Sequentially list conditions, if any, leeding to immadiate cause. Enter Underlying Ceuse (Disease or Injury Dua to (or as a consequence of) that initiated avants resulting in death) Last Dua to (or as a consequance of): Pert II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 | Yee 2 No 3 | Probably 4 | Unknown UN 24b. Wara autopsy findings aveilable prior to completion of cause of death? 24a. Was en autopsy performed? ab 2 No 1 ☐ Yes 2 ☑ No 1 🗆 Yes 25. Wes case refarred to medical axeminer? 28. Plece of Death (Check only one) Hospital: 1 Yes 2 No Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 inpatiant 2 ER/Outpatient 3 DOA 27. Manner of Deeth 28e. Data of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 28f. Location (Streat and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Physician /Medical Examiner

Examiner

Physician/Medical

by

Completed

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Certification:

edical

Physician

/Medical

Examiner

Director

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tem 27 is marked other than "natural", or fems 23s or 28s-f show other traumatic event, the Medical Examinal must be notified at

pemit. Pages 1 end 2 should be filed within 72 hours efter t Department of Health and Mental Hyglene. Important: If Nem 27 is marked other than "natural", or Net any injury or other traumatic event, the Medical Examinar

Saltimore, Maryland 21215-0020

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After this certificate has uneral

certificate be executed P.O. Division of Vital Records. al or Attending P s efter death. I Director: After i of in by the funera filled in by Hospital c 24 hours To the I

> State Registrar

31. Date filed (Month, Dey, Year)

29b. Signature and title of certifier

4 ☐ Homicide

(Check only one)

29a. Certifier

29c. Licanse number

JURSIM

1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

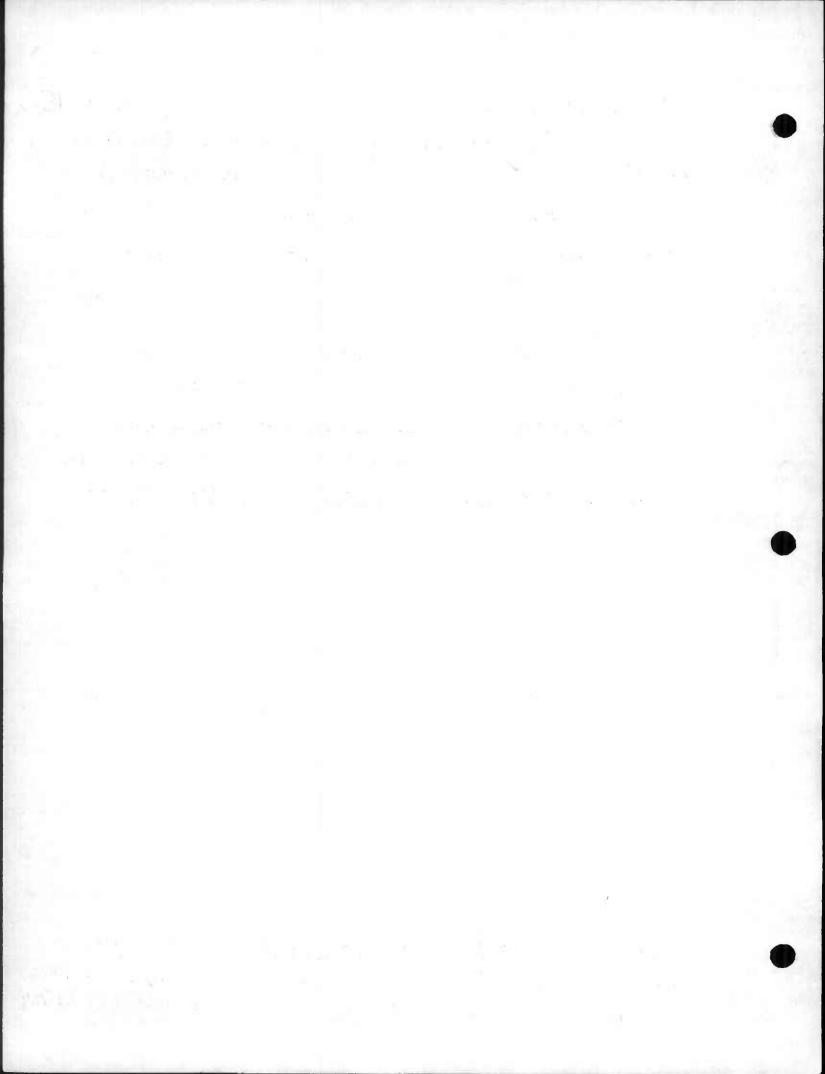
mestine 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

datamined

MI

32. Registrar's Signeture

This Avenue Home, 7200 Third Avenue, Sykesville, MD 21784



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Deeth 3. Time of Death Dev Year **Physician** 2325 Joseph Harbinger 12 98 4c. County of Death /Medical 4e Fecility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Medical 5 of 5. Social Security Number Maryland If Under 24 Hrs. 8. Date of Birth (Month, Day, Yaar) 6. Sax 7. Aga (In yrs. last birthday) Birthplace (Stata or Foreign Country) **Funeral** Months Days 1₽M 2□ F 36 216-64-5124 **Director** April 18,1962 Maryland Usual Rasidanca of Decedant with the Meryland 10a. Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yas 2 No Director Montgomery Olney 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 17907 Gainford Place 20832 U.S.A. 14. Raca - Amarican Indian, Funeral death 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yas, Give ૐ Yaar or Datas: 13. Was Decedant of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status Bleck, White, atc. e filed within 72 hours after all Hygiene. 1 X Nevar Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☒ No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highast grada complated) Elamantary/Secondary (0-12) Collaga (1-4or 5+) 12 Auto Conversions Managerial 17. Fether's Name (First, Middle, Last) 18. Mothar's Name (First, Middla, Maldan Sumama) Pages 1 and 2 should be fill ment of Health and Mental Hant: If Itam 27 Is marked oth Joseph Ludwig Hartinger Mary Ellen Hubble 19a. informant's Name/Ralationship (Type, Print) 19b. Meiling Address (Straat and Number or Rural Routa Number, City or Town, State, Zip Coda) 17907 Gainford Place Olney, MD 20832 Data 200. Location - City or Town, Stata Mrs. Susan M. Granta (Sister) other 20a. Mathod of Disposition Placa of Disposition (Nama of cemetary, cramatory or other place) 20 Burial 2 Cramation 3 Ramoval from Stata Depertment of Important: If any Injury or once. Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 8/17/98 Silver Spring, MD 21. Signature of Funaral Sarvica Licensee 22. Nama and Addrass of Facility HAIGHT FUNERAL HOME & CHAPEL (Box 195) let 2 Sykesville, MD 21784 (410) –795–1400 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heert failure. List only one ceuse on each line. Approximata Interval Batween Onsat and Death **Physiclan** /Medical Immediate Ceuse (Final Graft versus host disease or condition rasulting in death) Examiner Examiner transpla Marrow the death certificete be executed physician end the buriel-trens Sequantially list conditions, if eny, leeding to immadiata cause. Enter Underlying Cause (Disease or injury that initiated avants rasulting in death) Last Dua to (or as a consaguanca of) Chronic Division of Vital Records, P.O. Box 68760, Myclogerous Physician/Medical Dua to (or as a consaquenca of): 98 signed by the aid be deteched f Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings available prior to complation of cause of death? Completed 24a. Was en autopsy performed? hes 1 Yas 2 No 1 ☐ Yas 2 ☐ No or Attending Physician: effer deeth. Director: After this certific funerel director, 25. Was casa rafarrad to medical examiner? 26. Piece of Death (Check only ona) Be Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) 10 1 Yas 2 No 1 Impatiant 2 ER/Outpatient 3 DOA 27. Mennar of Death 28c. Injury at Work? 28d. Describe how Injury occurred Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 5 Panding invastigation 1 Naturel 2 Accident 6 Could not be datarmined 3 Suicide 28a. Placa of Injury - At home, farm, straat, factory, office building, atc. (Specify) 28f. Location (Straat and Number or Rural Route Number, City or Town, Stata) 4 Homicida - Hospital 24 hours Funeral C 29e. Cartifian 1🗲 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and placa, end due to the cause(s) and mannar as stated. Medicai (Check only one) 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. To the Vithin 2

State Registrar

31. Dete filed (Month, Day, Year)

22

29b. Signatura and titla of cartifier

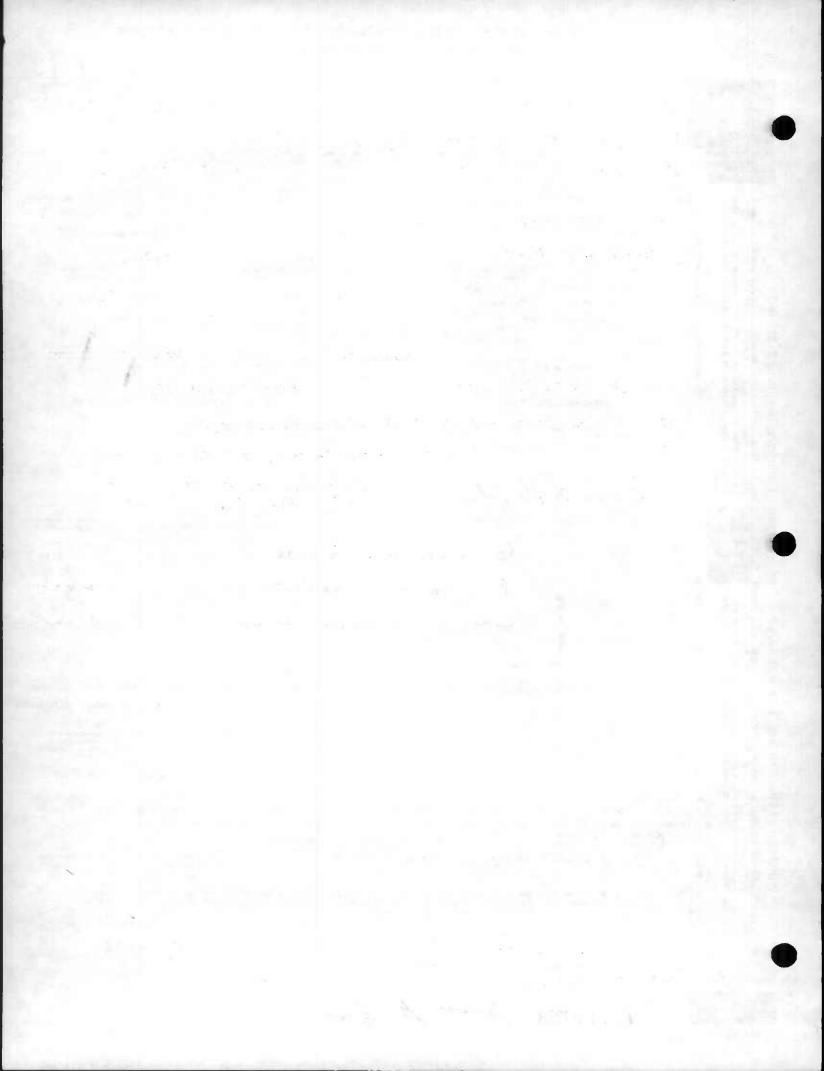
32. Registrer's Signature

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) BRENT GROTCH MD

Baltmore,

29c. Licansa numbar

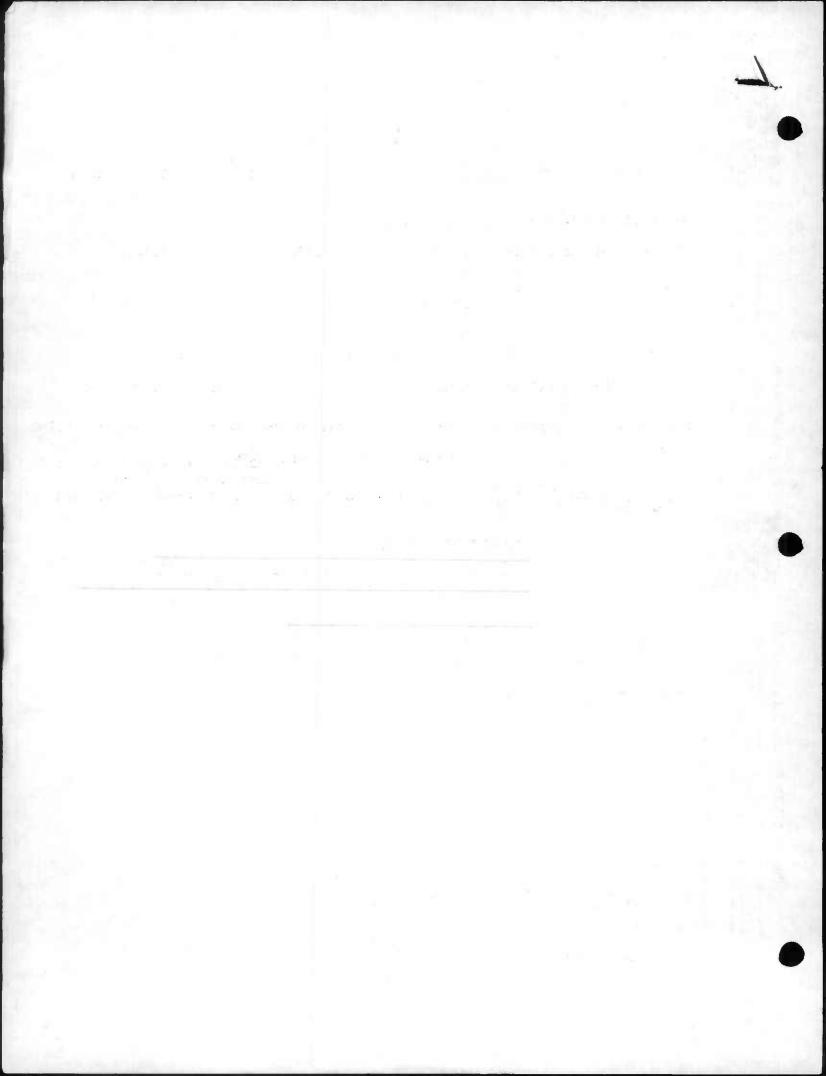
29d. Date signed (Month, Day, Yaar)



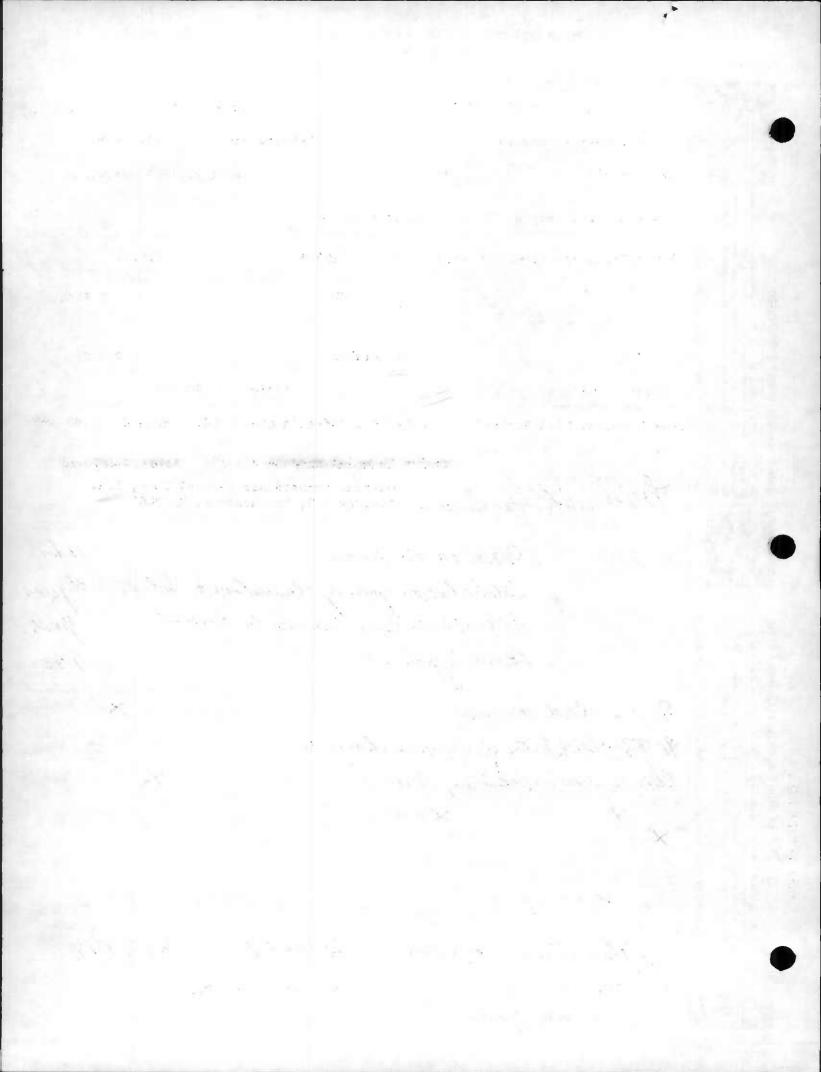
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State of Maryland / Department of Health and Mental Hygiene

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Mo sa		Usuel Residence of Decedent 10a, Steta 10b, County	10c. (City, Town or Location				10d. Inside City Lim
H H	tor	Maryland Washing	ton H	lagerstown				MXYas 2
23a or 28	al Director	10e. Street end Number 11 West Baltimor	e Street	10f	. Zip Code 21740		10g. Citizen of W	•
natural, or items 23a or 28a-f show adical Examiner must be notified at	by Funeral	11. Maritel Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Dacadent Ever in Armed Forces? 1 🖾 Yes 2 🗆 No. If Yes, Give W • W • Yaar or Datas Kore	TT s 1 TVe	ecedent of Hispenic Origin? (specify Cuban, Mexican, Pueus 20 No Specify:	(Specify Yas or No- orto Rican, atc.)		a - Americen Indian, k, Whita, atc. : white
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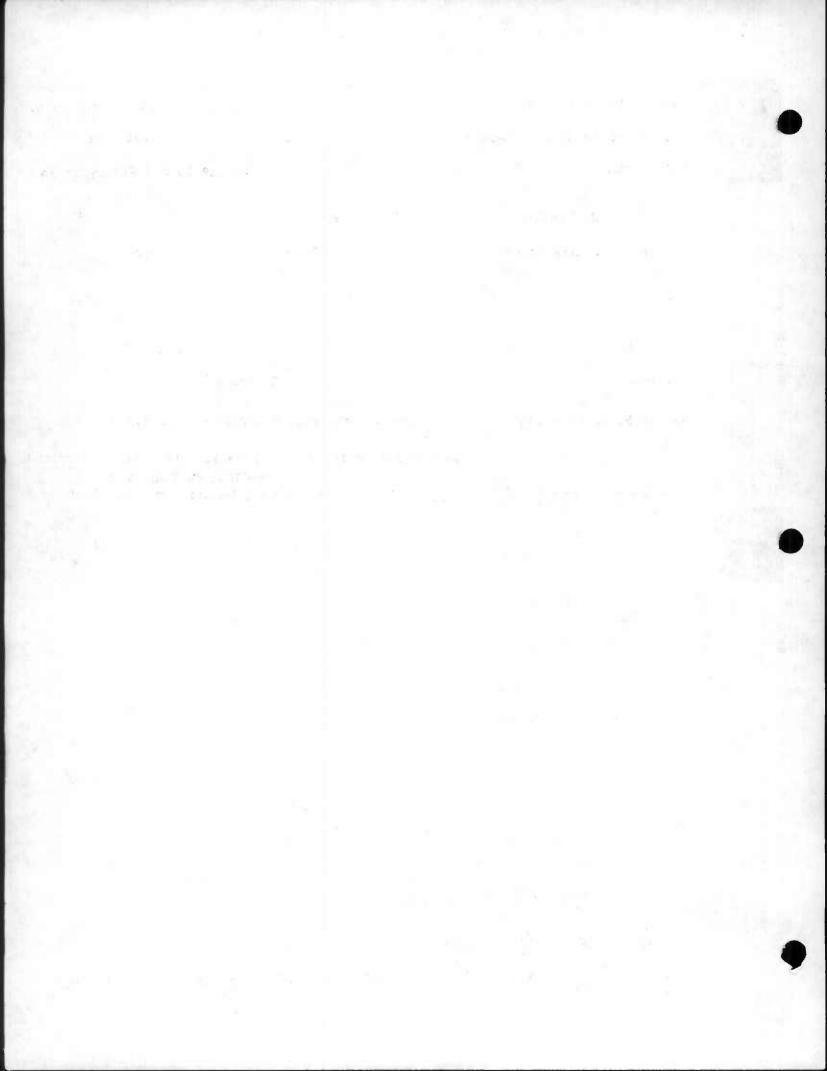
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Death Month **Physician** Genevieve Marie Jones 9:00 p.m. August 22, 1998 /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth Examiner 4c. County of Death Colton Villa Nursing Center Hagerstown Washington 5. Social Security Number 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth (Month, Dey, Yeer) Birthplace (State or Foreign Country) 1 □ M 2 🖾 F Months Days 214-09-9543 Director 84 Aug. 18, 1914 Pennsylvania Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. Clty, Town or Location items 23a or 28a-f show 10d. Inside City Limits the Medical Exeminer must be notified 1 XYes 2 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 119 West Antietam Street 21740 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours efter 1 Never Married 2 Married Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2 ☒ No Specify: þ 3 Widowed 4 □ Divorced Specify: white Be Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) laborer shoe mfg. marked other 17. Fether's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Meiden Surname) Peges 1 and 2 should be nent of Health end Mental Roy Brant Lula Downs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) permit. Peges 1 and 2 Department of Health er Important: if Item 27 is any Injury or other trav 0) Ronald H. Lucas - son 1204 Wabash Ave., Hagerstown, Md. 21740 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8-26-98 Rest Haven Cemetery Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such es cerdiac or respiretory arrest, shock, or heer failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final diseese or condition resulting in death) ATKE POSCLEROTIC CARDIOVASCULAR DISTASSE 1 year Examiner Physician/Medical Examiner year CBRB BROVASCULAR ACCIDBNI Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after deeth.

Funeral Director: After this certificate has been signed by the attending physician and the bunal-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Last Due to (or as a consequence of): P.O. Box 68760, Wery Due to (or as e consequence of) none Part II. Other algniffcant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? signed by the 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown nace Division of Vital Records, þ Completed 24a. Wes an autopsy 24b. Were autopsy findings eveilable prior to completion of ceuse of death? performed? 20 No 1□Yes 2 No 1 Tes funeral director, 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No Menner of Death 28e. Date of Injury (Month, Day Yeer) 28b. Time of Injury 28c. Injury at NA 28d. Describe how injury occurred 5 Pending Investigation To the Hospital or Attendin within 24 hours after deeth.

To the Funeral Director: At completely filled in by the fu NA 1 Yes 2 No 2 Accident NIA NA 6 Could not be 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homlcide NIB 1 Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner es steted.

2 Medicel Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D 28365 8-23-98 30. Name and address of person who completed cause of death (tem 23a) (Type, Print) HAPI. 368 MILL STREET HACEMTOWN 19021740 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 2 5 1998 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death ROBERT THOMAS JONES 2. Data of Death 3. Time of Death -Month Physician /Medical Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner If Under 24 Hrs mid Leanges 7. Age (In yrs. last birthday) If Under 1 Year Months Days Birthplace (State or Fereign Country) 8. Date of Birth (Month, Day, Year) Sept. 19, 1 5. Social Security Number Funeral Days Hours 18 M 2 F 139-12-9201 1923Pennsylvania Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d Inside City Limits 1 ☐ Yes 2 XNo Maryland Prince George's Directo Brandywine 288-71 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? 8 10505 Cedarville Road 3-3 20613 USA "natural", or hams 23a 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, Whita, etc. of fled within 72 hours after do if Hygiene. other then "natural", or flem 1X Yes 2 No WWII Year or Dates: 1 Never Married X Married White Baltimore, Maryland 21215-0020 1 Yes 2X No Specify: Specify à 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled w Department of Health and Mantal Hygien Important: If Item 27 is marked other tha any Injury or other traumeric and sons. Stone Mason Mason Union Local # 1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 88 unknown unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10505 Cedarville Rd., 3-3, Brandywine, MD 20613 Nancy A. Jones 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 1 XBurial 2 Cremation 3 Removel from State 4 Donation 5 Other (Specify) Maryland Veterans' Cem. 8-26-98 Cheltenham, MD 22. Name and Address of Facility
Huntt Funeral Home, Inc. 21. Signature of Euperal Strvice Licenti David A. Goff M01095 P. O. Box 156, Waldorf, MD 20604 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one clause on each line. Physician Immediata Cause (Finat disease or condition resulting in death) /Medical c = 00 1 12 Examine Examiner U ROSEPS attending physicien end for use as the burial-transit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) Box 68760 Physician/Medical Dua to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Stonknown hom þ 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 00 1 ☐ Yas 2 ☐ No 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Hospital: 1 Appatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 this. To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral 28d. Describe how injury occurred 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the tima, data and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. edical 29a. Certifier (Check only one)

State Registrar

29b. Signature and title of certifier

Suresha 31. Data filed (Month, Day, Year)

AUG 2 5 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

. Patelno

32. Registrar's Signatura

Deneva

DHMH 16 Rev 6/95

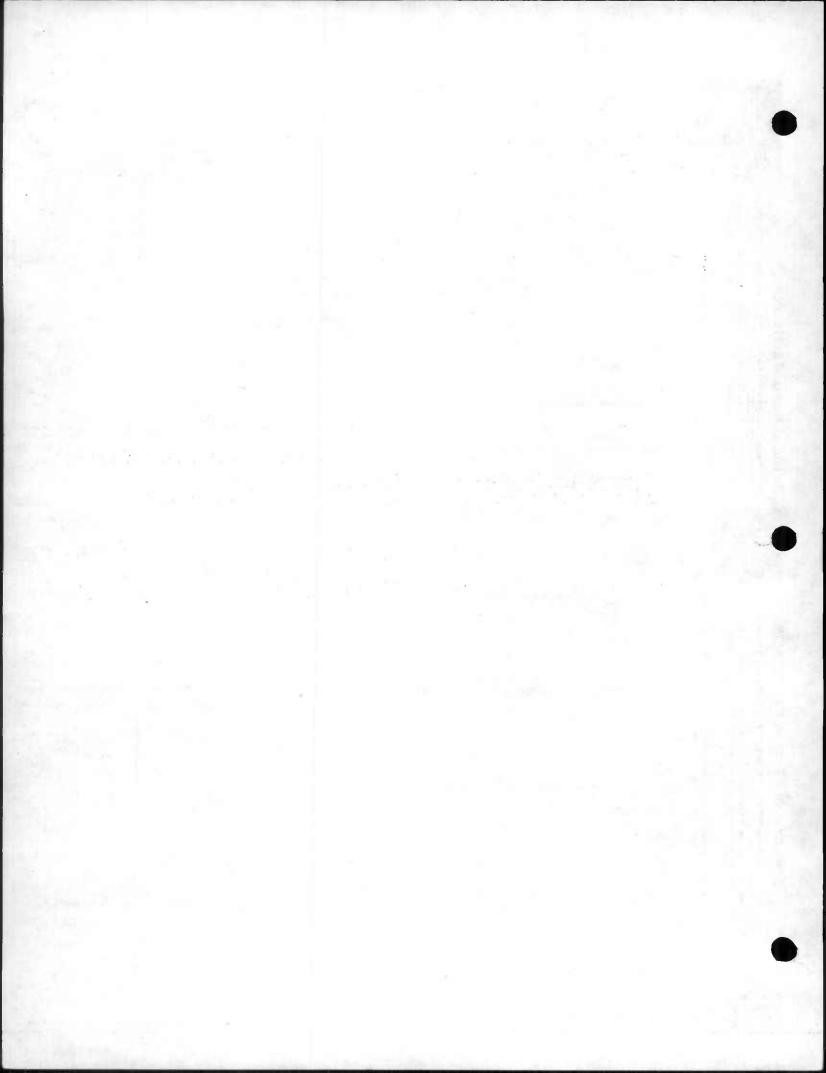
29c. License number

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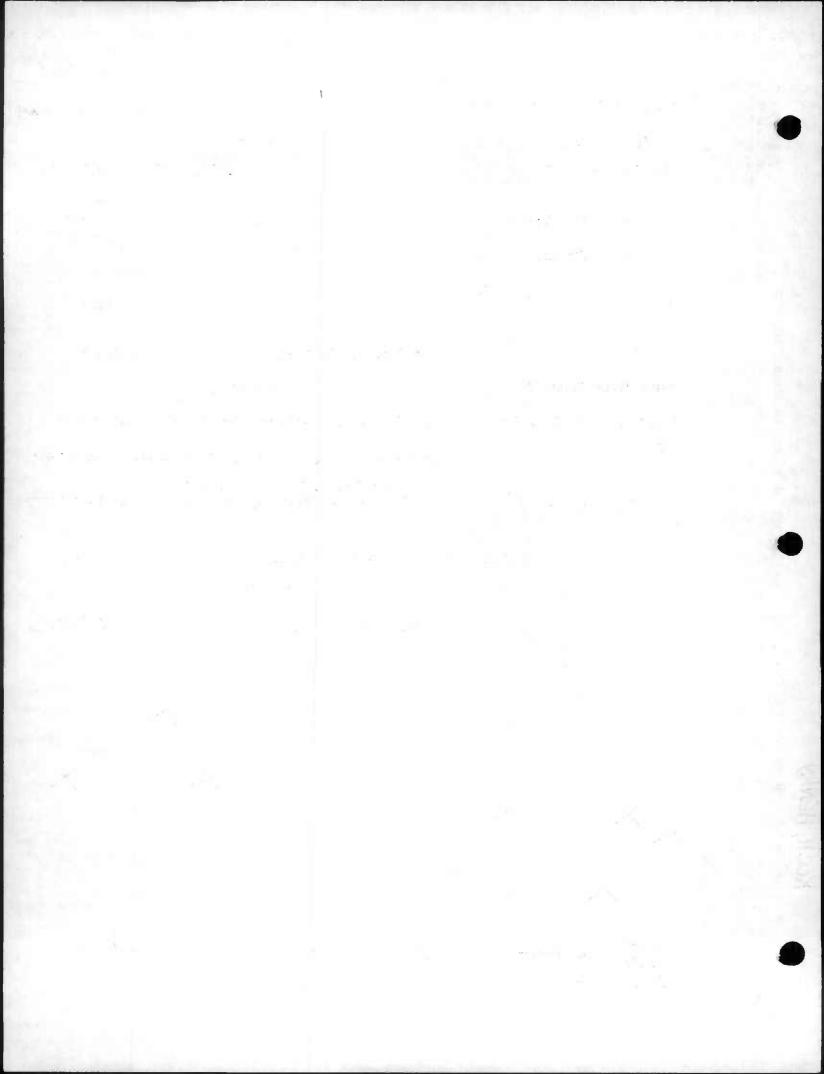
,7501 Surratts Rd # 307, clinton MD20731

29d. Date signed (Month, Day, Year)

8-21.98



	1	Decedant's Name (First, Middla, Las	t)		Cer	tificate o	f Death	2. Data of De	Reg. No.	0 6	3. Tima of Deeth
sician		Henry Jacob Koch	,					Month	Day	Yaar	
edical miner		. Facility Nama (If not Institution, give		r)			4b. City, Town,	or Location of Daat		1998 of Death	01:52 AM
mme		Washington County						rstown			ington
ral tor	5.	Social Security Number 6. St 195–05–1962	X 7. A	age (In yrs. 86	last birthday) Yrs.	If Undar 1 Ye Months Dey	ar If Undar 24 H	lrs. 8. Data of Bir in. Aug. 24	th Y91911	9. Birthp	laca (Stata or Foraign Sylvania
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ō			ngton	100. 01	y, 10wn or 200		Hagersto	vii)			0d. Insida City Limits 17☑ Yas 2☐ No
Director	10	De. Street and Number	ingcon			10f. Zip Code		WII	10g. Citizan of \	What Coun	41
		411 Belview Avenu	ie				21742		rog. Onizari or i	USA	
y Funeral		I. Maritel Status 1 □ Navar Marriad 2 □ Married	12. Was Decadan Armed Forces 1 Yes 28	? No		Vas Decadant o Yes, specify C		(Specify Yes or No arto Rican, atc.)	14. Rac Blac Specifi	e - Amaric ck, White,	an Indian, etc.
d by		3X Widowed 4 □ Divorced	Yaar or Datas	:						WU	ite
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ToB		Henry Jacob Koch	Sr.				Ida Re	ebman			
To		9e. Informent's Name/Ralationship (7	ype, Print)			_		Rural Routa Numb			
		Henry J. Koch, I	II, Son					Hagerstow			
	20	De. Method of Disposition 1 ☑ Surial 2 ☐ Cramation 3 ☐ 4 ☐ Donation 5 ☐ Othar (Specify		0		sition (Nama of latory or other p en Ceme		Aug. 27	20c. Location -		wn, State Maryland
once.	2	1. Signature of Funaral Sarvice Licens	107			Douglas	_	y Funeral			land 21742
an al	In	Sa. Part1. Enter the disease or comp shock, or heart failure. List only o	ne ceusa <i>on</i> aabh	lina.	h. Do not ante	er the mode of o				, and y	Approximata Intarval Batwaen Onset and Death
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edical	th ra	equantially list conditions, any, laading to immediata ausa. Entar Underlying ause (Diseesa or injury at initiated events sulting in daath) Last	c. AF		as a consequ	wA rance of):	LL DET	USCEN	32		4DAYS
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2	-	1 ☐ Yes 2 No	Hospital: Jopan		ER/Outpatient	3LI DUA		Homa 5 ☐ Rasi	4.44.44		y)
ation:	27	Mannar of Deeth Natural 5 Pending Accident Invastigation	28e. Data of In (Month, D	ury ay Year)	28b. Tima of Injury	28c. In V	jury et /ork? □ Yas 2 □ No	28d. Dascribe	how injury occur	red	
Medical Certification: To Be Com		3 Sulcida 6 Could not be datarmined	28a. Place of Ir building, a	njury - At ho tc. <i>(Spacif</i>)	ome, farm, stra	at, factory, offic	е	28f. Location (City or To	Street and Numb wn, Stata)	per or Rura	I Routa Number,
edicai	25	Pa. Cartifier (Check only one) Certifying Phy 2 Medical Exam	aician: To the best nar: On the basis and menner s	of axaminat	wledge, daeth tion end/or Inv	occurred at tha astigation, in m	tima, data and pla y opinion, daath oo	ace, and due to the ocurred et the tima,	cause(s) and ma date end placa,	annar as st and dua to	ated. the ceuse(s)
×	29	b. Signetura and title of certifiar					nsa number		29d. Date signe	d (Month, I	Day, Year)
	30	. Name and drass of parson who c	omplated cause of	daath (Itam	23a) (Type F		4447)	8/2	3/	78
		ILANA WEST		STO			CAL C	CHNIC			
		. Data filed (Month, Day, Yaar)									



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Daath 3. Tima of Death 1. Decedent's Nama (First, Middla, Last) Day Month Yaar **Physician** 98 DIXO 4c. County of Death /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) Examiner CARROLL COUNTY GENERAL HOSPITAL WESTMINSTER CARROLL Birthplaca (Stata or Foraign Country) If Undar 1 Yaar If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) DEC 30, 1936 5. Social Security Number 7. Aga (In yrs. last birthday) 6. Sax **Funeral** Months 1√ M 2□ F Days Hours 215-32-3793 61 WEST VIRGINIA Director Usual Rasidance of Decedant permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Heelth and Mentel Hygiene. Important: If then 27 Is marked other than "natural", or flams 23a or 28a-f show any Injury or other traumatic event, the Maryland Process. 10d. Insida City Limits 10a. Stata 10b. County 10c. City, Town or Location 1 ☐ Yas 2 ☒ No BALTIMORE REISTERSTOWN MARYLAND Directo 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 5 MAIN STREET 21136 USA Funeral 13. Was Decedant of Hispanic Origin? (Spacify Yas or No-lf Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, White, etc. 12. Was Decedant Evar in U,S. Armad Forcas? 11. Marital Status 1 ☐ Yas 2 ☑ No If Yes, Giva Yaar or Datas: 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 Yas 2X No Specify. WHITE Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Spacify only highast grada complated) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) 12 SELF EMPLOYED AUTO MECHANIC 18. Mothar's Nama (First, Middla, Maidan Surnama) 17. Fathar's Nama (First, Middla, Last) ELLA MAE ALKIRE ROBERT GRANT KITZMILLER 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) 2103 CELESTE CT, HAMPSTEAD, MD 21074 JEFFREY KITZMILLER, SON 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Date 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata CARROLL CREMATIONS 8/17 HAMPSTEAD, MD 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility 21. Signatura of Funaral Sarvica Licensea ELINE FUNERAL HOME une 934 SOUTH MAIN ST, HAMPSTEAD, MD 21074 23a. Pert1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximata Intarvel Betwaan Onsat and Daath **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in daath) Examiner Examiner JTERIOR The law requires that the deeth certificate be executed Sequantially list conditions, if any, laading to immadiata ceusa. Entar Undarlying Ceuse (Disaasa or Injury that Initiated avents rasulting in daath) Last pue ettending physicien for use es the buria Box 68760, Physician/Medical Dua to (or as a consequanca of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contributa to the cause of death? ed by the deteched o signed by t d be detech 4 Unknown 3 Probably 1 Yes 2 No by Records, 24b. Wara autopsy findings available prior to completion of causa of daath? Completed 24a. Was an autopsy peen hes 2 No 1 Yas 1 ☐ Yas 2 ☐ No this certificete Division of Vital funeral director, Physician: 25. Wes case refarred to medical axaminar? Be 28. Placa of Death (Check only ona) Hospital: Othar: 4 Nursing Home 5 Rasidance 6 Othar (Specify) 1 Yas 2 No Inpatiant Certification: To 2 ER/Outpetient 3 DOA 28a. Data of Injury (Month, Day Year) he Hospital or Attending Phin 24 hours after death.

he Funeral Director: After the pietely filled in by the funeral 27. Mannar of Death 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred Natural 2 Accident 5 Panding 1 Yas 2 No Invastigation 6 Could not be datarmined 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 3 Suicida 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stete) 4 ☐ Homicida Sertifying Phyalcian: To tha best of my knowledga, daath occurred at tha tima, date end place, and dua to the ceuse(s) end mannar as stated. 29a. Cartifian Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, end due to the causa(s) and manner stated. compietely (Check only one) within 2 29d. Date signed (Month, Day, Year) 29b. Signature end titla of certifier 29c. Licansa number eo, se of deeth (Item 23e) (Type, Print) 31. Date filed (Month, Dev 32. Registrar's Signatura State

DHMH 16 Rev 6/95

Registrar

AUG 1 9 1998

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Leslie Woodrow Lind August 22 1998 4:55pm /Medicai 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Northampton Manor Nursing Home Frederick Frederick 7. Age (In yrs. last birthdey) If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 6. Sex 1 ☑ M 2 ☐ F 5. Social Security Number 9. Birthplece (State or Foreign Country) **Funerai** 175-10-8088 Yrs 83 Director May 4, 1915 Maryland Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or items 23a or 28a-f shore Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Frederick Woodsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 206 S. Second St. 21798 U.S.A. Pagas 1 and 2 should be filed within 72 hours after deeth nent of Health end Mental Hygiene.
Int: If items 72 Is marked other then "natural", or items 23.
Inty or other traumatic event, its Medical Exercise mustry or other traumatic event, its Medical Exercise must Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indien, Black, White, etc. 11 Maritel Stetus 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: White g 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Foreman Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Leslie E. Lind Orpha Bostian P 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Mary Louise Lind/wife 206 S. Second St. Woodsboro, MD. 21798 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pagas Department of Important: If it any Injury or o 1 Burial 2 □ Cremation 3 □ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 8/25/98 Ladiesburg, Md. Haugh's Cemetery 21. Signature of Funeral Service Lib 22. Name and Address of Fecility Hartzler Funeral Home 404 S. Main St., Woodsboro, MD 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth Physician /Medical Immediate Cause (Final disease or condition resulting in death) ADVANCED Years SCLERODERMA Examiner Due to (or as a consequence of) Examiner Days MALNUTRITION AND DEHYDRATION law requires that the death certificate be executed physician and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Lest Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as a consequenca of): attending pl signed by the all Part II. Other eignificant conditione contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown þ 24a. Was en eutopsy performed? 24b. Were autopsy findings evelleble prior to completion of cause of death? Completed has pege 2 1 Yes 2 No cartificate 1 ☐ Yes 2 ☐ No Hospital or Attanding Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 27. Manner of Deeth 28a. Dete of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after deeth 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide within 24 hours a

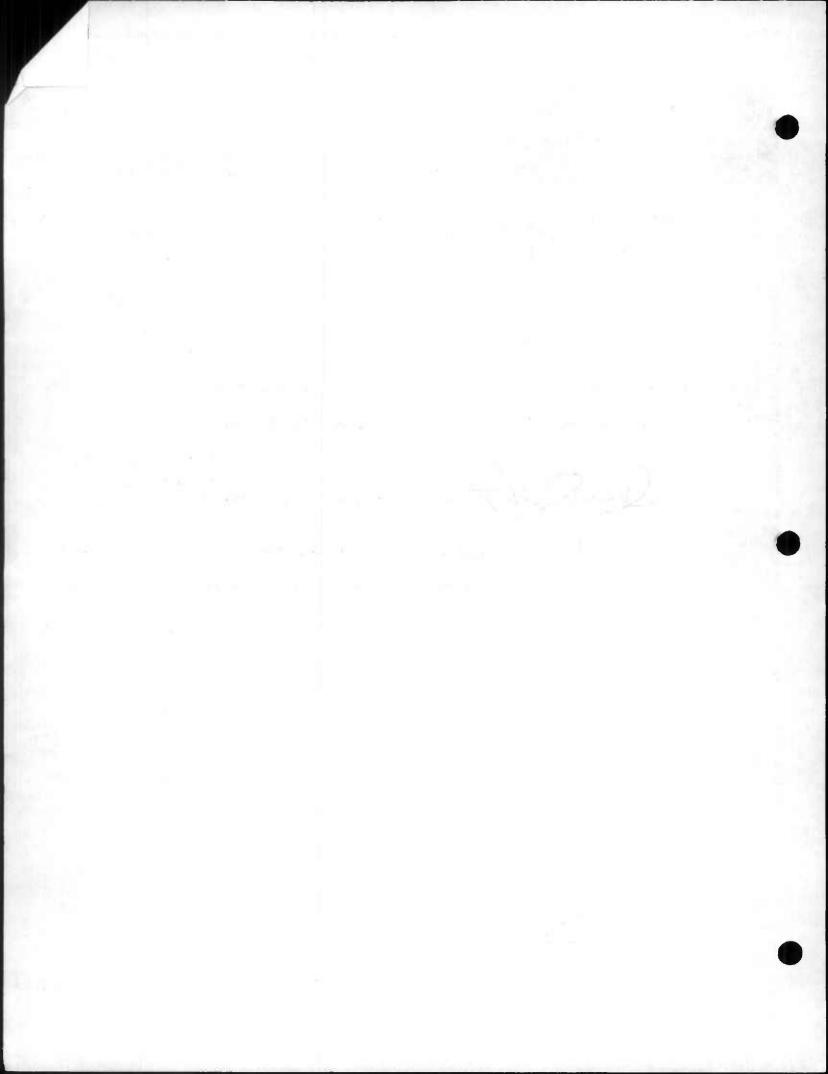
To the Funeral C

completely filled 29a. Certifier 1 🗷 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) end menner as steted. edicai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D43091 8-24-98 30. Neme and address of person with completed cause of death (Item 23a) (Type, Print) HOUSE AND PREDENCY MD 2001 STEEN TAIDI 801 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

AUG 2 5 1998



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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_	4	417-30-01/00	7. Age (In yrs. lest birthday) H Ur Mont	der 1 Year If Under 24 Hrs. hs Days Hours Min.	8. Dete of Birth (Month, Dey, Year)	9. Birthplace (State or Fo
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		John b	molelator	D2544:	3	8-1898
	15	Name and address of person who con	mpleted cause of death (Item 23e) (Type, Print)	John W. Middlet	on, M.D.	1 21157

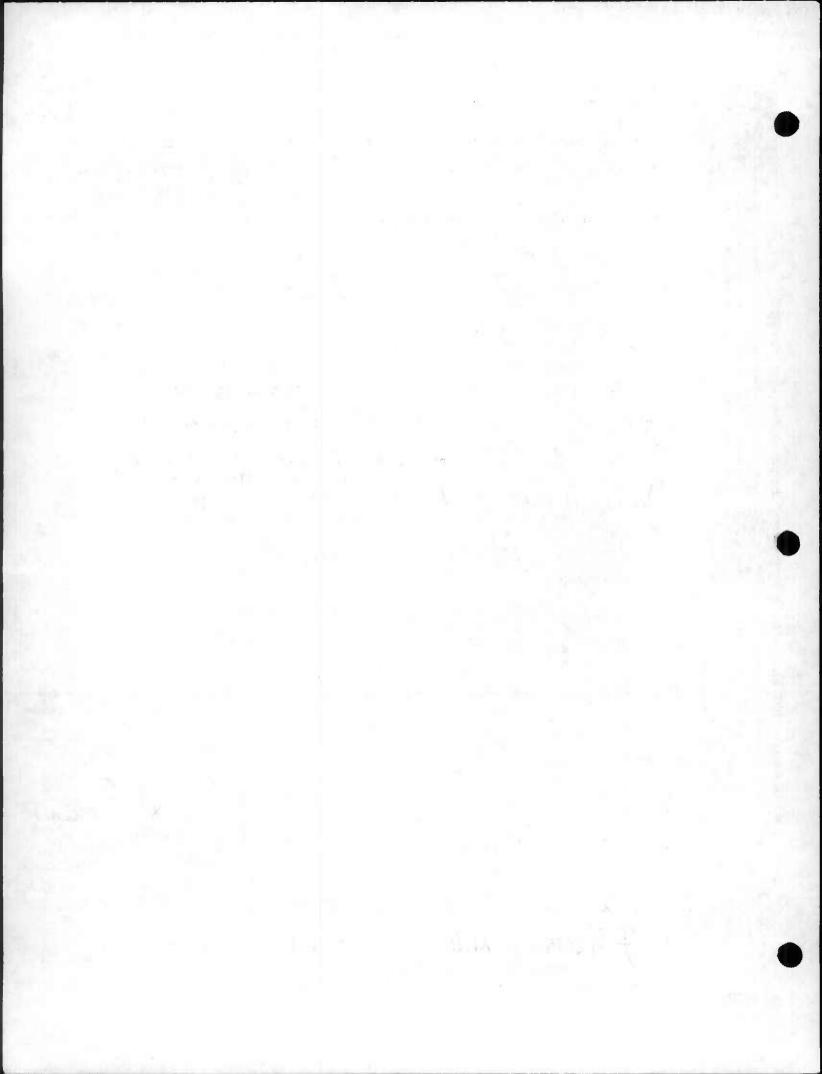
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98-4979-043 hnw/crn Scott E. Miller

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State of Maryland / Department of Health and Mental Hygiene

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State	:	JOSEPH PE				's Signature					MD	2120	Τ				
Registrar			NUG 2 6 1			we	G.	de	Park	41							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Year Raymond Todd McCarney RAYMOND MCCARNEY AUGUST 5:45 AM 23,1998 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death BACTIMORE Baltimore City UNIVERSITY OF MARYLING MEDICAL SYSTEMS - 16 SOUTH GREENE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) JUNE 15, 1965 9. Birthplece (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Days 1 M 2 □ F 33 Yes 215-94-2357 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 21 No Md. Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13740 Pa. Ave. 21742 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispenic Orlgin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Painter Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Raymond S. McCarney Joyce L. Lorshbaugh 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 21721 19a. Informent's Name/Relationship (Type, Print) 21012 Twin Springs Dr. P.O. Box 68 Chewsville, Md. Raymond S. McCarney (Father) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition Date 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from Smithsburg Crematory Aug. 24, 1998 Smithsburg, Md. □Donahon 5 □Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Fecility 12525 Bradbury Ave. Davis Funeral Home Smithsburg, Md. 21783 23a. art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heer feilure. List only one cause on each line. Immediate Cause (Finel disease or condition resulting in death) BACTERIAL ENDOCARDING SIX HONTHS Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings evailable prior to 24e. Was en eutopsy performed? completion of ceuse of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No. 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medicai Examiner

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Division of Vital Records, P.O. Box 68760

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Pages 1 and 2 should be filed within 72 hours etter and of Health and Mantel Hygiana.

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Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.

END STAGE RENAL DISEASE

25. Wes cese referred to medical examiner?
1 ☐ Yes 2 ☑ No 27. Manner of Death 1 Natural

2☐ Accident 3 ☐ Suicide

4 Homlcide

(Check only one)

29a. Certifier

5 Pending investigation

6 Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 No 28d. Describe how injury occurred 28f. Location (Street end Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

LARRY, MARYLMA 20723

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

Rubertan when NF MD

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P12477

AUGUST 23, 1998

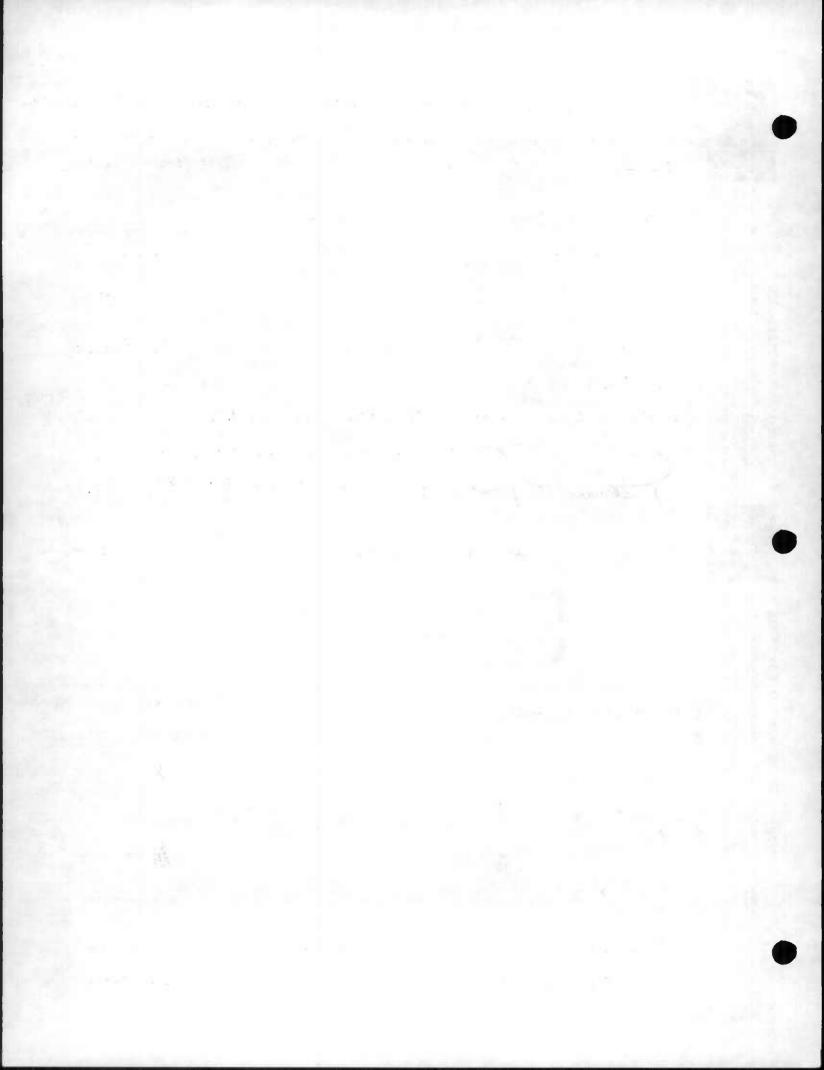
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LOSHUA M.F. RUBENGELD 31. Date filed (Month, Day, Year)

32 Registrar's Signature

9738 COUNTRY MEADOWS LAME- #13

State Registrar



State of Maryland / Department of Health and Mental Hygiene

1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month Dey Yeer August 2.2 1998 8:30 AM							Certifica	te of	Death		Reg. No.	8 27224
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30. Name and address of person who completed cause of death (item 23e) (Type Print)		After fune	tlon	1 Neturel 5 ☐ Pending	(Month, Day	Year) 200. In	jury	Wo	rk?		andw mjury occurre	ru
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30. Name and eddress of person who completed cause of death (from 23e) (Type Print)	Hospits	24 hours Funera letely fille		29a. Certifier (Check only 2 Medical Exam	niner: On the basis of	examination and	deeth occurred /or investigation	et the ti	me, dete end p opinion, deeth o	elece, end due to the	e cause(s) end man e, date and place, er	ner as stated. nd due to the cause(s)
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31. Date filed (Month, Day, Year)

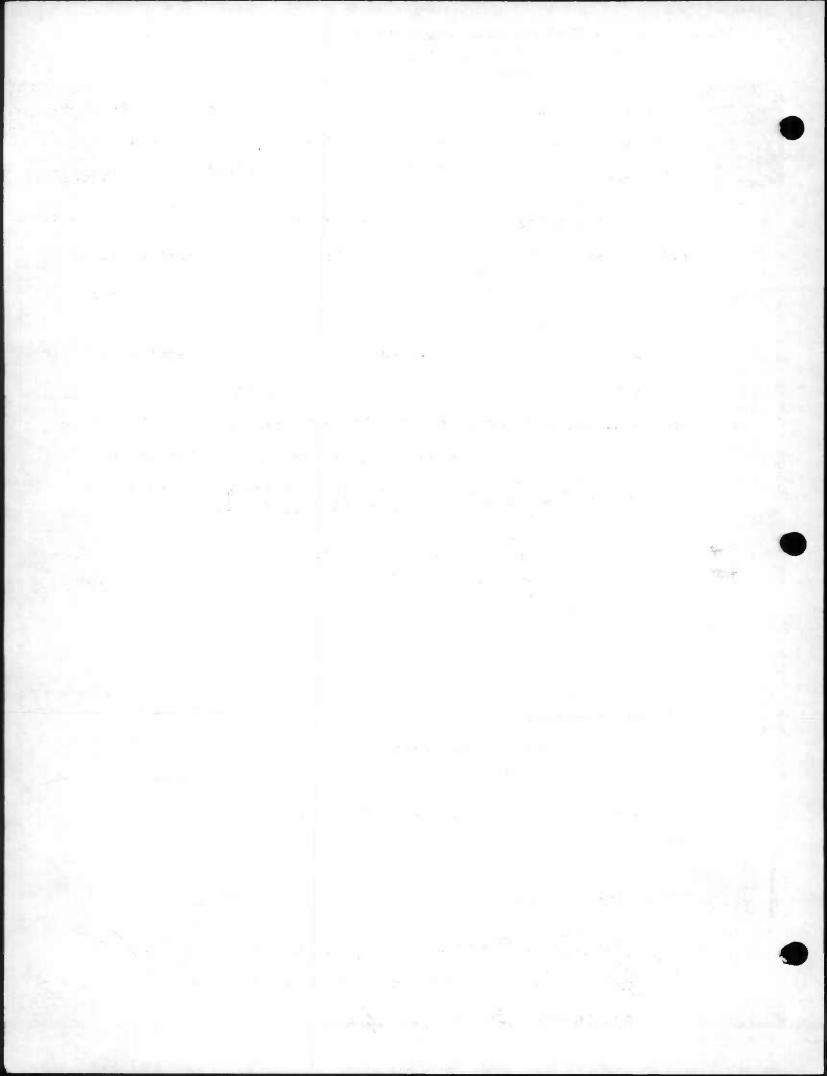
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32. Registrar's Signature

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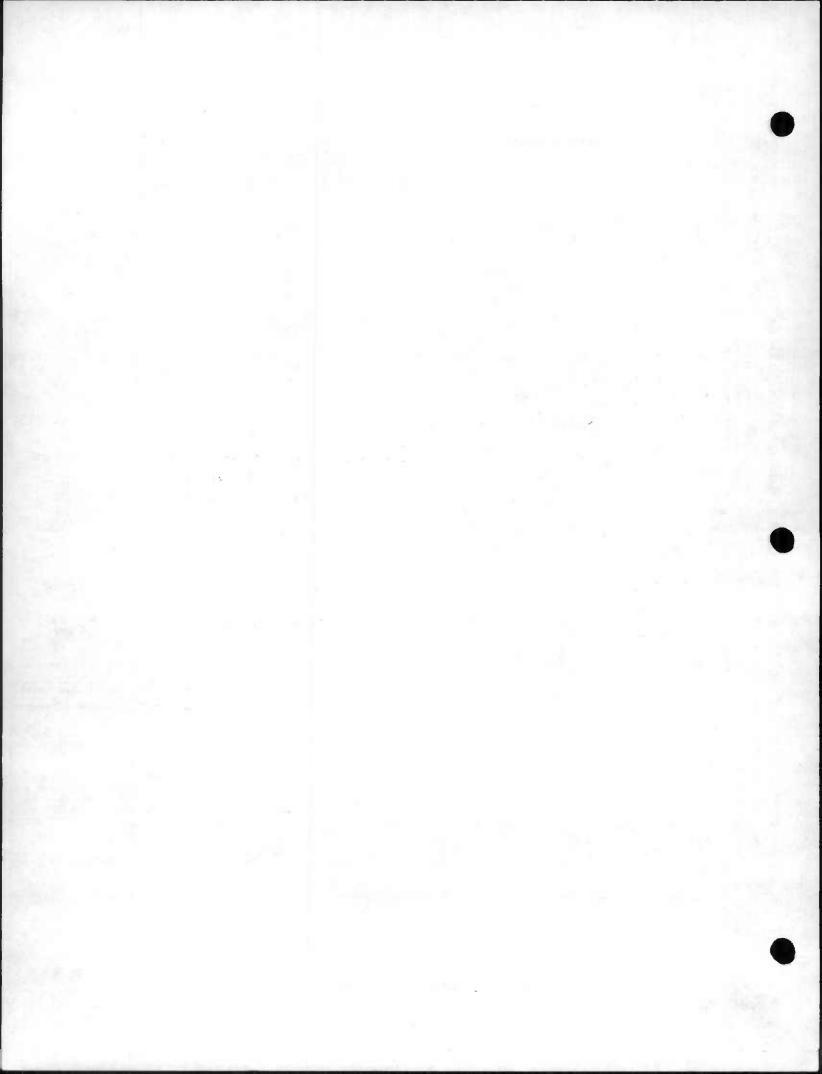
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saitimore,	age ent of t: #		20e. Method of Disposition 1 \ Burial 2 \ Cremetion 3 \ Removel from State 4 \ Donation 5 \ Other (Specify)	or other pied			oc. Location - C Hurloc	k, MD
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	Dhi.a.la.a.		23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the shock, or heart feilure. List only one ceuse on each line.	erals mode of dyin	burg, MD ng, such es cardiac o	2163 or respiretory erres	st,	Approximete Intervel Between Onset end Deeth
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DIVISION	or Attendent ifter deat Director: in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)			28f. Location (Str. City or Town,	eet end Number Stete)	or Rural Route Number,
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Day Year **Physician** AUG. 1998 EVELYN MARIE NEEDY 23 6:40 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Hagerstown Washington Coffman Nursing Home If Under 1 Yee If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1□ M 2Ĭ F 89 212-03-6280 1909 Virginia Director Aug. Usuel Residence of Decedent 10a State 10c. City, Town or Location 10b County 10d Inside City Limits 1⊠Yes 2□No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 609 Sunset Avenue 21740 USA tterns 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 11 Meritet Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 72 hours after 1 Never Merried 2 Merried 8 white Baltimore, Maryland 21215-0020 1 Ves 2 No Specify à 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. filed within Elementery/Secondary (0-12) College (1-4or 5+) 1± secretary of admission University 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Bessie Nauman John W. Phillips 19e. Intorment's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) or other trac Audrey M. Baker - daugther 117 East Green St., P.O. Box 192, Funkstown, Md. 21734 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from Stete Rose Hill Cemetery 8-27-98 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Fecility 21. Signeture of Funeral Service Licenses MINNICH FUNERAL HOME 415 E.Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** Immediate Cause (Finel disease or condition resulting in deeth) /Medical Examiner Examiner sician and burial-transit The law requires that the death certificate be executed Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last physician is the bunal Box 68760, Physician/Medical 080 P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy tindings eveilable prior to completion of cause of death? 24a. Was an eutopsy performed? Completed page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Was case reterred to medicat examiner?

1 Yes 2 No Be 26. Piace of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. tnjury et Work? 1 Watural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after deat Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 | Homicide Hospital 29a. Certifier 1th certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated. Medical tely 2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, deeth occurred at the time, date and plece, end due to the cause(s) end menner stated. (Check only one) within 2 94 29b. Signature end title of certifieg 29c. License number 29d. Date signed (Month, Day, Year) D 36655 30. Neme and eddress of parson who completed cause of death (Item 23e) (Type, Print) 1185 Mt. Aetna Road Samuel Chan, MD Hagerstown MD 21740 31. Date filed (Month, Day, Year) 32/ Registrer's Signeture State Registrar AUG 2 6 1998



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month 6:55 AM August 26,1998 Helen Elizabeth Nunley 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Fecility Neme (If not institution, give street and number) Prince George's Southern Maryland Hospital Clinton If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Dey, Year) APRIL 13,1918 Birthplace (Stete or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Hours 1□M 2XF Deys Months 80 280-07-6644 Usuel Residence of Deceden 10c. City. Town or Location 10d. Inside City Limits 10e. Stete 10b. County 1 Yes 2 No Maryland Prince George's Morningside 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 6610 Suitland Road 20746 U.S.A. 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritel Status Bleck White efc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White If Yes, Give Yeer or Dates: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) 10th N/A Homemaker Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Mary Elizabeth Frank Gerz 19b. Melling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) Rose Ann White (Daughter) 6702 Poplar Road Morningside MD 29746 20b. Plece of Disposition (Name of Aug 28. 1998) cometery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) Washington National Cemetery Suitland, Maryland 22. Name and Address of Facility Lee Funeral Home, Inc. 21. Signeture of Funerel Service Licensee 6633 Old Alexandria Ferry Rd Clinton, MD20735 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heart feilure. List only one ceuse on each line. Approximete Intervel Between Onsef end Death Immediate Ceuse (Final disease or condition resulting in deeth) SERVICE PULMONARY DISSES Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in deeth) Last Due to (or es a consequence of) Due to (or es a consequence of): 23b. Did tobacco usa contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveilable prior to 24a. Was en eutopsy performed? completion of cause of deeth?

Physician /Medicai Examiner

The law requires that the death certificete be executed

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Directo

Funeral

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Completed

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours effer death with the Maryland Depertment of Health and Mentel Hygiene. Important: if item 27 is marked other than "naturel", or items 23a or 28e-1 show eny injury or other treumstic event, the Medical Exemple.

Examiner physician end s the burief-transit Physiclan/Medical 98 ettending use (signed by the e þ peen certificete hes

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27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Inj	jury et	28d. Describe how In	jury occurred							

5 Pending investigation 1 Neturel 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide

28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier 🛣 Cartifying Physician: To the best of my knowledge, death occurred et the time, date end plece, and due to the cause(s) and manner es stated

2 Medical Examinar: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, dete and piece, end due to the cause(s) and manner stated. (Check only one) 29d. Dafe signed (Month, Day, Year)

29c. License number 29b. Signafure end fitte of certifier

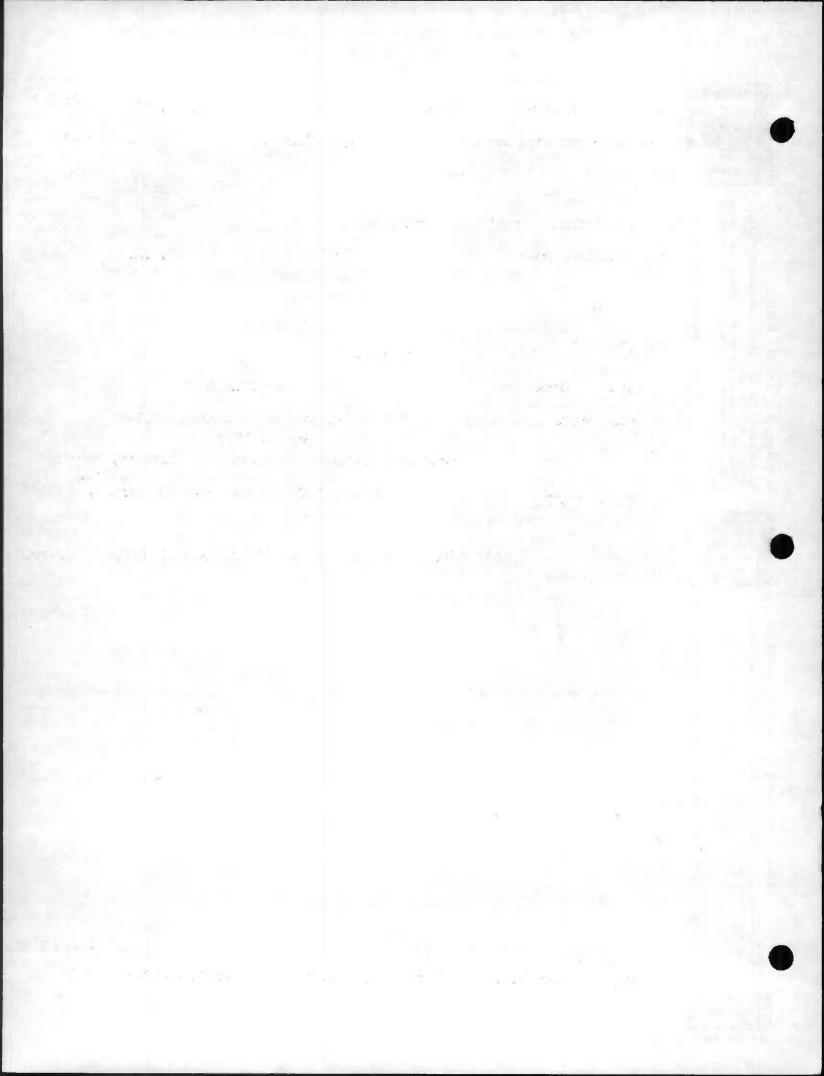
30. Name end didess of person who completed cause of deeth (frem 23e) (Type, Print)
Philip Wisotsky M.D. 700 Old Line Center #207 Waldorf, Maryland 20602

State Registrar 31. Dete filed (Month, Day, Year)

32. Registrar's Signeture

Hospital or Attending Physician: 24 hours effer death.
 Funeral Director: After this certifical elely filled in by the funeral director, it

within 2



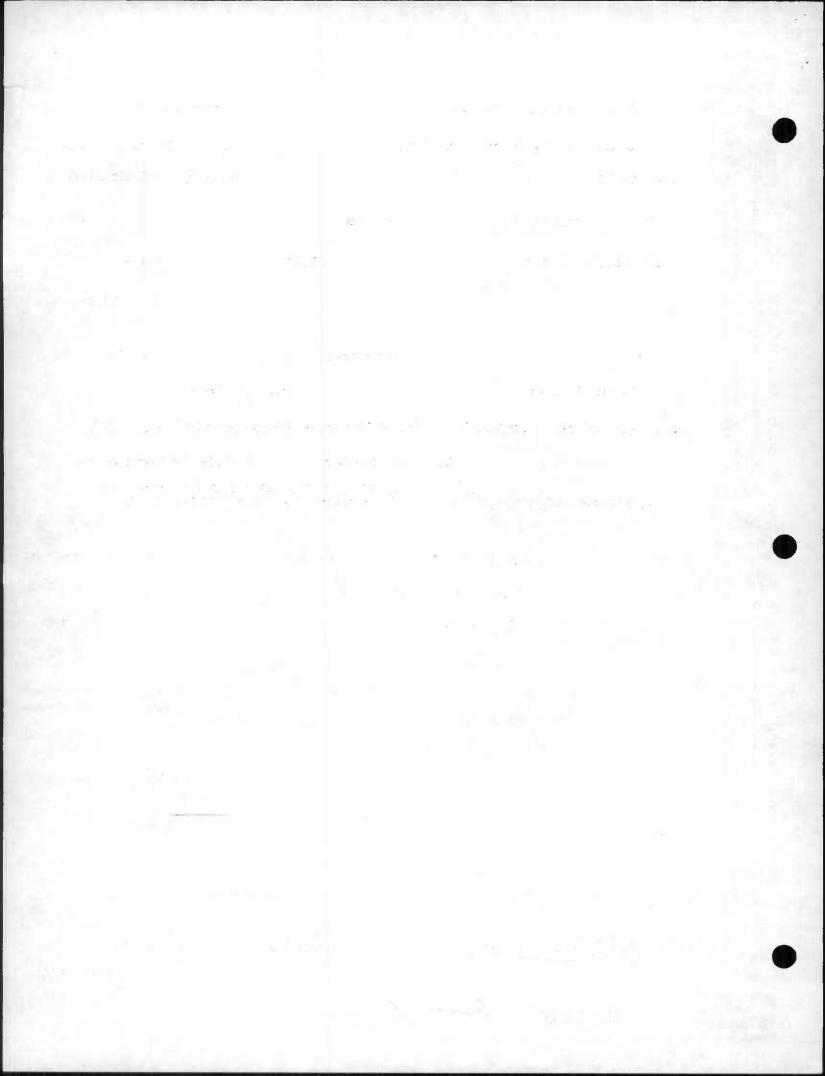
Amended Item 2, per Phy., 9/2/98, Carroll County, wjl Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Item #26, Per Phy. 8/19/98, Carroll County, wjl Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deat August 17 1998 3. Time of Death Month **Physician** 18, Ethel Virginia Norris 1998 August /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner Carroll County General Hospital Westminster
If Under 1 Year | If Under 24 Hrs. | 8. Date of Carroll County Birthplace (Stete or Foreign Country) 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Dey, Yeer) **Funeral** Months Days Hours Min. 1□ M 2√2 F 94 Yrs. Director June 6, 1904 Maryland 220-18-4543 Usual Residence of Deceden with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Medical Examiner must be notified at NE Yes 2 □ No Director Carroll MD Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death v
Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a and Injury or other traumatic event, the Medical Examinat mans once. Funeral 7610 Norris Avenue U.S.A. 14. Rece - American Indian, Black, White, etc. 21784 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: by 3€ Widowed 4 Divorced Black Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 8 Homemaker Domestic 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumame) Be James Johnson Isabelle Boardley 19a, Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) c/o: 7610 Norris Avenue Sykesville, MD 21784
ace of Disposition (Name of Date 20c. Location - City or Town, State Mrs. Mary Collins (Daughter) 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Ramoval from State 8/21/98 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) St. Luke Cemetery 21. Signature of Funeral Service Licensee 22. Name end Address of Facility HAIGHT FUNERAL HOME & CHAPEL (Box 195) Sykesville, MD 21784 (410)-795-1400 ean 23a. Part1. Enter the disease, or complications that daused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heert failure. List only one cause of each line. Approximate Interval Between Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) orebro vasan mnediate. **Examiner** RS Examiner attending physician and for use as the burial-transit that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events Due to (or as a consequence of DA Physician/Medicai Due to (or es e consequenca of): resulting in death) Last 1Rs 0 signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 Yes þ 24b. Were autopsy findings evailable prior to should I Completed 24a. Wes en eutopsy performed? completion of cause of deeth? page 2 has 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate or Attending Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) To Hospital: Other: 4 Nursing Home -1 Yes 2 No 3D DOA 1 Inpatient 2 ER/Outpatient ■ 6 Other (Specify) this 28a. Dete of Injury (Month, Dey Year) funeral 27. Manner of Death 1 Matural 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? Affer 5 Pending s after death. 1 ☐ Yes 2 ☐ No investigation 2 Applient the 6 Could not be 3[7] Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hoapitai 24 hours edical 29e. Certifier 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, end due to the cause(s) end menner es steted within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 7016206 an 30. Name end eddress of persen who completed cause of death (Item 23a) (Type, Print) ELDERSBURG, Md 21784 VALLON, N.D. CARROLL PRIMORY CARE, PA. ELIZABETH

State Registrar 31. Date filed (Month, Dey, Yeer)

AUG 1 9 1998

32. Registrer's Signeture

Division of Vital Records, P.O. Box 68760,



Physician /Medical Examiner The lew requires that the deeth certificate be executed pue Box 68760 physician the

Physician

/Medical

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State Registrar

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AUG 26 1998

30. Name and address of person w

32. Registrar's Signature Geneva

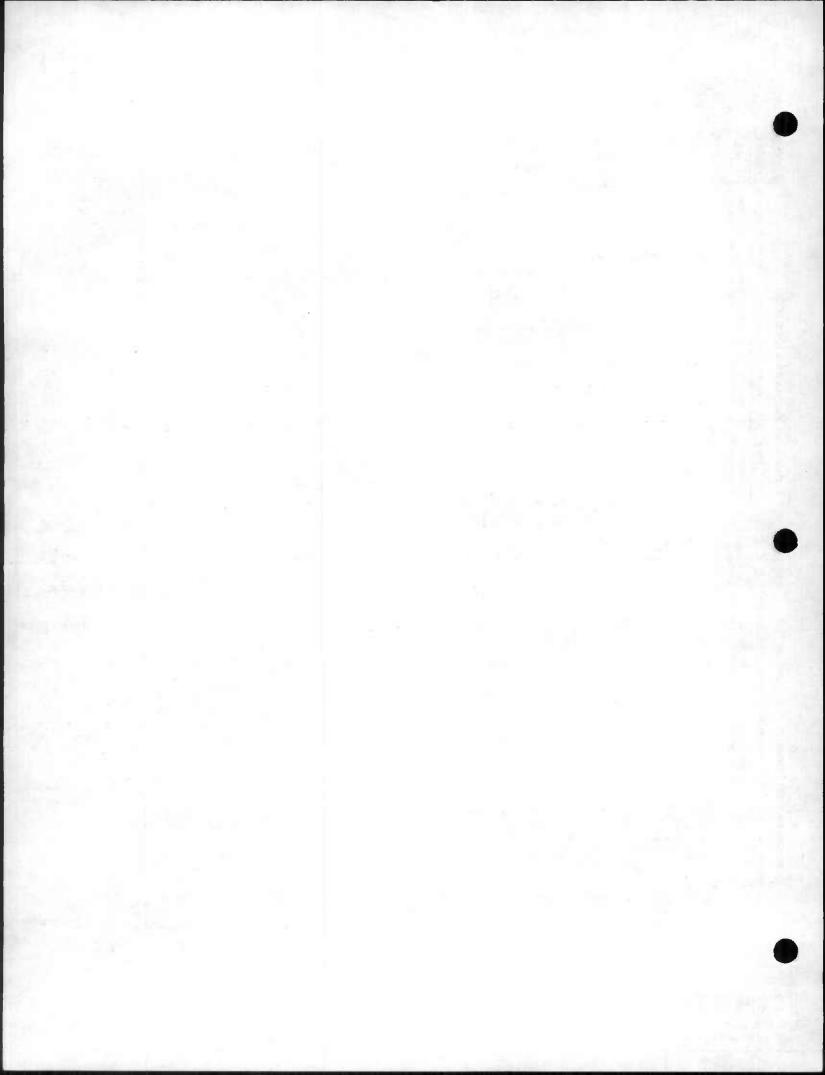
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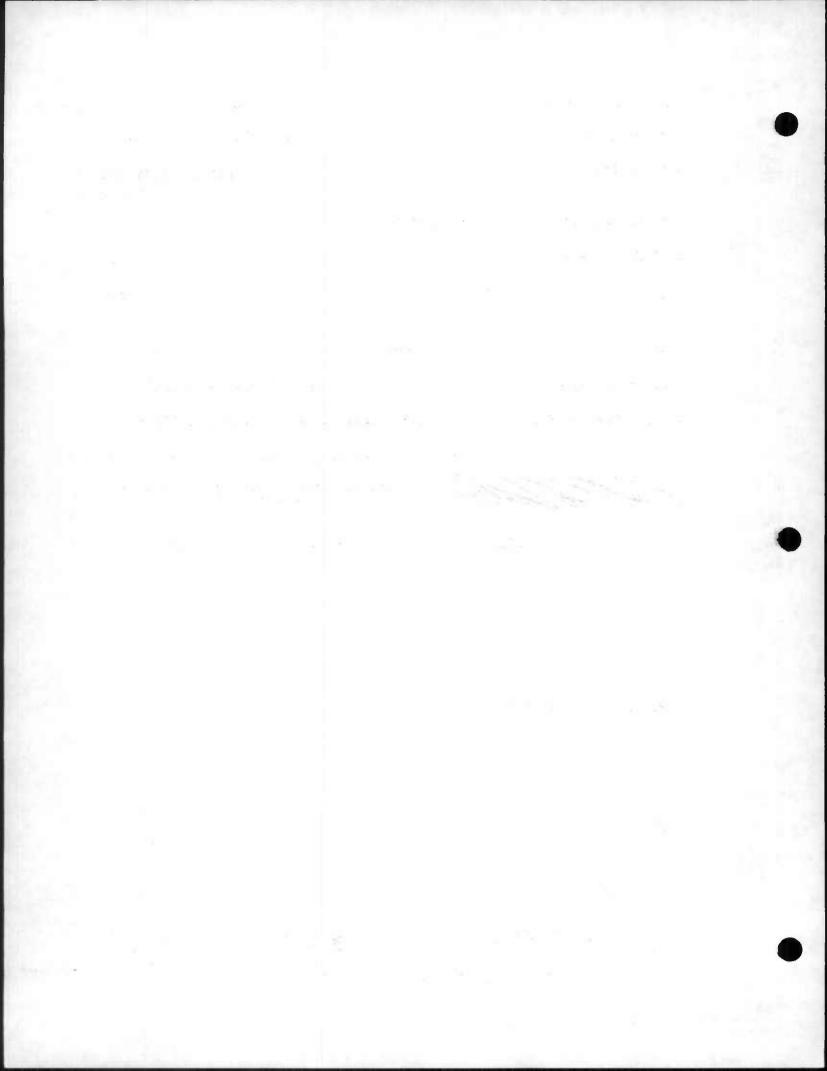
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No FOUND 1. Decedent's Name (First, Middle, Last) 2. Deta of Death 3. Time of Death 22, 1998 **Physician** 09:00 PM THAPDEUS PLEASANT AUGUST FOUND /Medical 4c. County of Death 4a Facility Name (If not institution, giva street end number) 4b. City, Town, or Location of Death Examiner BRANCH 7108 WOOD DRIVE CLINTON PRINCE GEORGES If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept 22, 1950 Virginia 5. Sociel Security Number 6. Sax 7. Age (In yrs. lest birthday) **Funeral** X M 20 F Days Months Hours 226 72 8684 47 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes TNO Director MD Clinton P.G. Berns 23s or 25s-f 10a. Street and Number 10f Zin Code 10g. Citizen of What Country? 7108 Branchwood Drive 20735 United States Funeral 12. Was Decedent Evar in U,S. Armed Forcas? 14⊒ Yes 2 □ No If Yas, Giva Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Bleck, White, atc. after 1 Never Married 2 Married 8 1 Yes 2 No Specify: altimore, Maryland 21215-0020 Specify: Black by 3 ☐ Widowed 4 ☐ Divorced Yaar or Datas Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Asphalt Foreman Newton Asphalt Company 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be 8 and Mental Department of Health and Mental Important: If Hem 27 is marked or any injury or other traumatic ev pode. John Pollard Pleasant Jean Pleasants Pages 1 and 2 should 19e. Informent's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, State, Zip Code) Christine Pleasant/Wife 7108 Branchwood Drive, Clinton, Maryland 20735 20b. Plece of Disposition (Name of cemetary, cremetory or other plece) Aug 27, Dit 998 20c. Location - City or Town, State 20e. Method of Disposition 1 Burial 2 Cremation 3 Ramoval from Stete Cheltenham, Maryland Maryland Veterans Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Neme and Address of Fecility Lee Funeral Home, Inc 6633 Old 21. Signature of Funerel Service Licenses 20735 Alexandria Ferry Road, Clinton, Mary land)nth 23e. Part1. Enter the disaesa, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediate Causa (Final . ASPHYXIA disaasa or condition rasulting in deeth) Examiner Due to (or es e consequence of): Examiner SUSPENSION BY LIGATURE certificate be executed Sequentielly list conditions, if any, laading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequenca of) physician s the burial Box 68760 Physician/Medicai Due to (or as e consequence of) P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown signed b Records. p 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Wes an eutopsy performed? page 2 1 Yes 2 No 1 Yes 2 No certificate Division of Vital Hospital or Attending Physician: 24 hours after deeth. Funeral Director: After this certifice Be 25. Was cesa referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Injury at 28d. Describe how injury occurred Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury
(Month, Day Year)

28b. Time of Injury
O 1 O P M 1

28e. Plece of Injury At homa, farm, street, factory, office building, etc. (Specify) 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending SUBJECT HANGED SELF 1 Yas 2 No Investigation 2 Accident 3 Suicide

☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) HOME 7108 BRANCH WOOD DRIVE, CLINTON To the Hospital within 24 hours a To the Funeral Completely filled edlcai 1 Certifying Physician: To the best of my knowledge, deeth occurred et the tima, data and place, end due to tha cause(s) end mennar as stated.

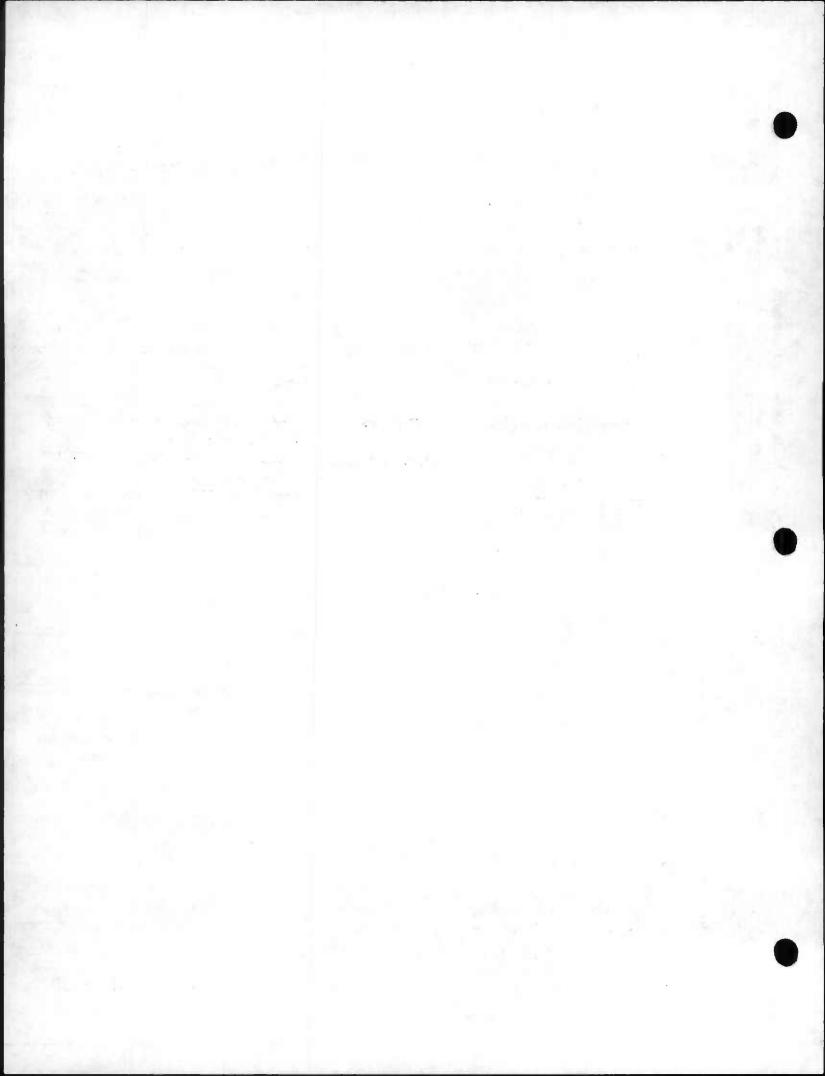
2 Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, deeth occurred et the tima, data and place, and due to the cause(s) end manner stated. 29a. Certifier 29b. Signature 29c. Licensa number 29d. Date signed (Month, Day, Year) DME AUGUST 30. Name and address of person who completed cause of geet) (Item 23a) (Type, Print) MARIO F 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785 GOL 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

AUG 27

1998



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 49 County of Death 4a Facility Name (If not institution, give street and number) Town, or Location of der 24 Hrs. 5. Social Security Number 9. Birthplace (State or oreign Country) Mary Land 4,1911 578-07-9720 Days **Usual Residence of Decedent** 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits Brandvwine Maryland Prince George's 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 11000 Cedarville Road 20613 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian. 11 Marital Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, apecify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Native 1 ☐ Never Merried 2 ☐ Merried 1 Yes 2 No Specify: Specify: American 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Sand and Gravel Co. N/A 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Cora Linkins William Joseph Proctor 19a. Informent'a Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11000 Cedarville Road Brandywine, MD 20613 RegeniaE. Proctor (Wife) 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State AugustDat 4. 1 Surial 2 □ Cremation 3 □ Removel from State 4 □ Donation 5 □ Other (Specify) 1998 Clinton, Maryland Resurrection Cemetery 22. Neme and Address of Facility Lee Funeral Home, Inc. 21. Signature of Funeral & 6633 Old Alexandria Ferry Rd Clinton, MD 20735 234 Part. Effer the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, about, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNEUMONIA RECURRENT ASPIRATION CEREBROVASCULAR ACCIDENTS Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ANEMIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? DEHYDRATION N/A 21 No 1 | Yes 2 | No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examiner Physician/Medical Examiner

physician and the burial-transit

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Completed

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Certification:

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29a. Certifier (Check only one)

The law requires that the death certificate be assouted

Box 68760.

P.O.

Division of Vital Records,

or Attending Physician:

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To the Hospital or Attanding within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun

Physician /Medical

Examiner

Funeral

Director

al', or items 23s or 28s-f show Examiner must be notified at

Director

Funeral

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Completed

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death

parmit. Pages 1 and 2 should be filed within 72 hours after a Department of Mealth and Mental Hygiena. Important: If Itam 27 is marked other than "natural", or Meany Injury or other traumatic available.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

25. Wes case referred to medical examiner?

1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Day Year) 28b Time of 28c. Injury et Work?

27. Manner of Death 1 Netural 2 Accident 5 Pending investigation 3 ☐ Suicide 6 ☐ Could not be 4 Homicide

28e. Plece of Injury - At home, ferm, atreet, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(a) and manner stated.

1 Tyes 2 No

28d. Describe how injury occurred

29b.	Sign	ature and ti	itle of certi	fier	
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AUG 27

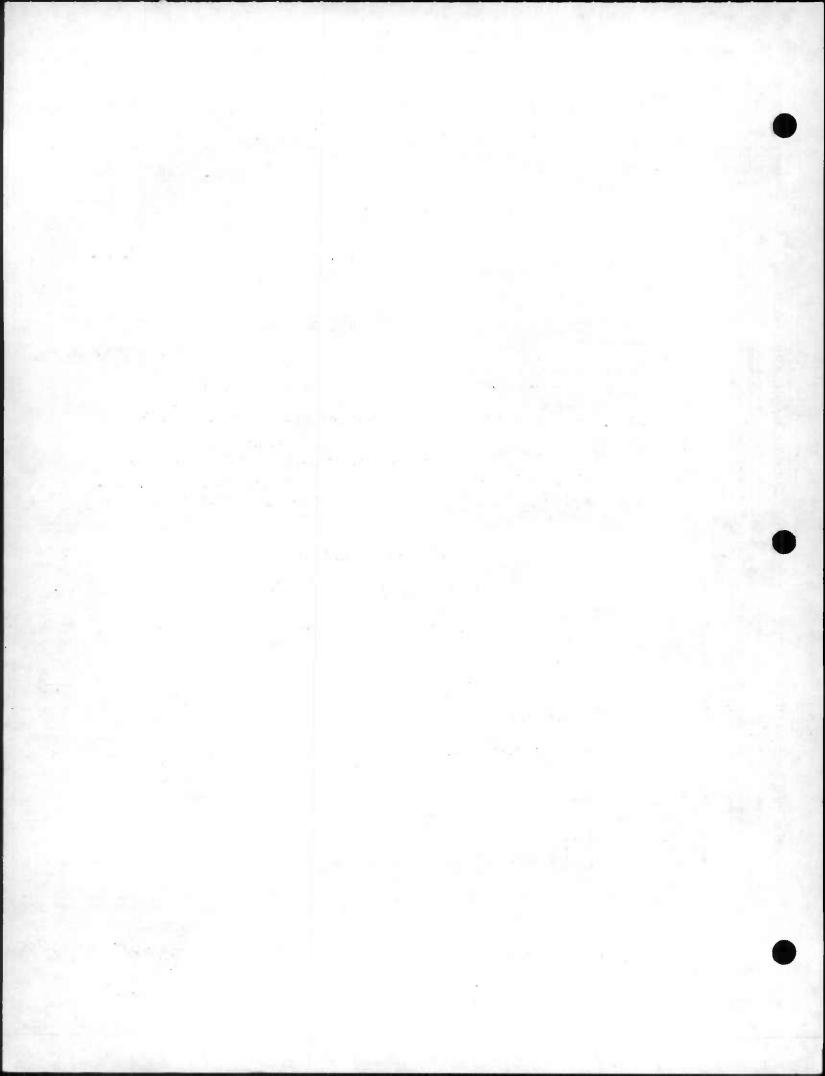
31. Date filed (Month, Day, Year)

29c. License number 029646 P.O. Best 975

State Registrar

address of person who completed cause of death (Item 23a) (Type, Print)

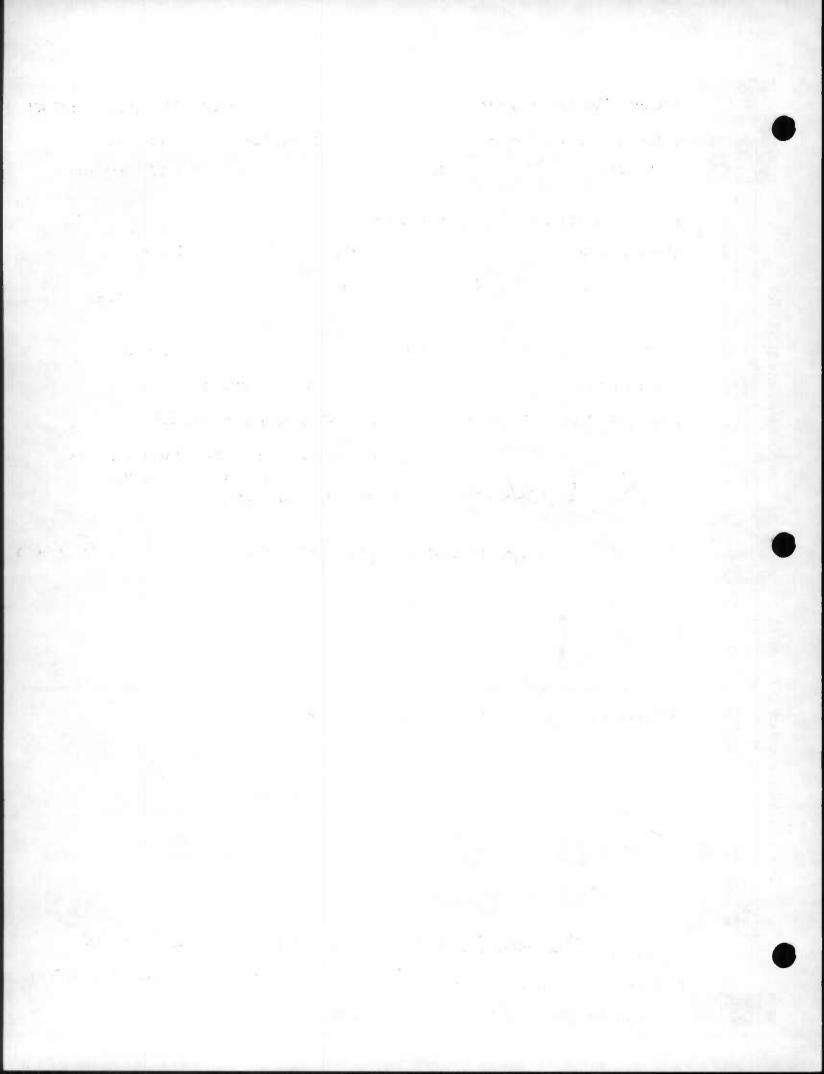
32. Registrer's Signature



State of Maryland / Department of Health and Mental Hygiene \ Certificate of Death 2. Dete of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Bernard Matthew Roberts 23, 1998 4c. County of Deeth August 3:25_AM /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street end number) Examiner Frederick Memorial Hospital Frederick Frederick 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) Birthpleca (Stete or Foreign Country) **Funeral** Yrs. 217-16-2443 79 Maryland Director Usual Residence of Decedent the Meryland 10d. Inside City Limits 10e State 10h County 10c. City. Town or Location 7 is marked other than "naturel", or items 23a or 28a-f show traumatic event, the Mexical Examinat must be notified at Yos 2□ No Director Maryland Frederick Libertytown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11905 Main St. 21762 U.S.A. deeth Funerai 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11, Marital Stetus permit. Peges 1 and 2 should be filed within 72 hours effer d Department of Health and Mentel Hygiene. Important: If Item 27 is marked other than "naturel", or item any Injury or other traumatic event, Ite Medical Examina-Bleck, White, etc. 1 Never Married 2 N Married 1□ Yes 2 No altimore, Maryland 21215-0020 Specify: Specify: Black p 3 ☐ Widowed 4 ☐ Divorcad Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Construction Laborer 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Name (First, Middle, Last) Charles Roberts Mary B. Dorsey 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informant's Name/Relationship (Type, Print) P.O. Box 152 Libertytown, Md. 21762 Sherrie M. Roberts/daughter 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 Buriel 2 Cremetion 3 Removel from Stete 8/27/98 Libertytown, Md. 4 ☐ Donetion 5 ☐ Other (Specify) St. Peter's Cemetery 22. Name end Address of Fecility Hartzler Funeral Home 21. Signeture of Funeral Servica Licansee Libertytown, Md. 21762 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert failure. List only one ceuse on each line. Approximate Interval Between Onset end Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or es e consequença of) Examiner physician and s the buriel-trans Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or es e consequenca of): certificate be execu Box 68760. Physician/Medicai Due to (or es e consequenca of): Se Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the causa of death? ed by the s P.0. 1 Yes 2 No 3 Probably 4 Unknown Dulmonary disease by Division of Vital Records. 24b. Were eutopsy findings aveileble prior to completion of cause of deeth? 24e. Was en autopsy performed? Completed has 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical exeminer? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No P 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 28e. Dete of Injury (Month, Dey Year) 28d. Describe how Injury occurred 27. Menner of Deeth 28b. Time of 28c. Injury et Work? Certification: 1 Naturel or Attending 5 Pending 1 ☐ Yes 2 ☐ No deeth. Investigation 2 Accident after deeth Director: 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 | Homicide Hospital 24 hours edicai 29a. Certifier 1 🖰 Certifying Phyalcian: To the best of my knowledge, deeth occurred et the time, date and plece, end due to the ceuse(s) end menner as stated. (Check only one) 2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. To the F within 2 29d. Dete signed (Month, Dey, Year) 29b. Signature end title of cartifia 29c. License number 48184 30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print) Street Prederick MD 2170 Es Kander MD Elhamy 31. Date filed (Month, Day, Year) 33. Registrer's Signeture

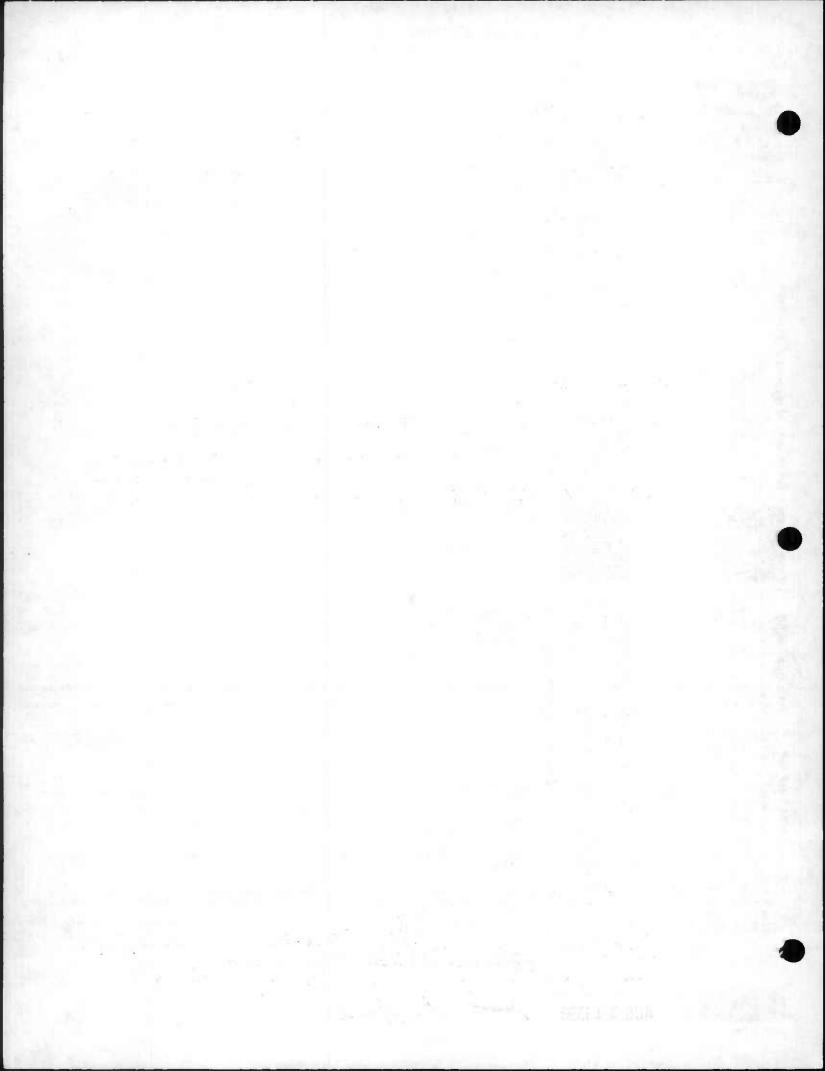
State Registrar

AUG 2 5 1998



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 98 27237

						Cei	tificate o	f Death		R	eg. No.		
		\square	1. Decedant's Nama (First, Middla,	Last)						2. Date of Deat	th		3. Tima ot Death
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Di To the Hospital or	within 24 hours ofter deeth. To the Funeral Director: After th completely filled in by the funeral		29a. Cartifiar 1 Certifying I	hywicium: 50 tha	best of my knowl	ledga, daath	occurred at that	ima, data an	d place, a	nd dua to tha ce	usa(s) and ma	nnar as st	ated.
2	n 24 ne Fi	edicai	one)	and man	asis of examination	n and/or inv	astigation, in my	opinion, daa	th occurre	d et the tima, da	ata and place,	and dua to	tha cause(s)
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) Rucker 23:26 August John 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number) General Hospital Westminster (7. Age (In yrs. last birthday) | H Under 1 Year | H Under 24 Hrs. | 8. Date of Birth (Month), Dey, Year) County Arroll CArroll Birthplece (State or Foreign Country) 5. Sociel Security Number 6. Sex 10 M 20 F 217-50-3358 50 Feb 21, Usuel Residence of Decedent 10e Stete 10b. County 10c. City, Town or Location 10d. fnslde City Limits 1 Yes 2□ No Carroll MD Westminster 10e. Sfreet end Number 10f. Zip Code 10g. Citizen of Whet Country? SA ennsylvania 2115 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 IM No If Yes, Give Yeer or Detes: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Raca - American Indian 11 Marital Status Bleck, Whife, etc. 1 Never Merried 2 Merried 1 Tyes 25 No Specify Specify: White 3 □ Widowed 4 Doivorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Kestaurant OOK 12 yrs 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Cucker 13 SIE Cornwe 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) JAMES P. Rucker TACKISH PED pperco (Brother) 15111 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, State 1 ☐ Burial 2 ② Cremation 3 ☐ Removel from Stete MD 8/19/98 Hampstend Carroll Cremation Inc 4 □ Donetion 5 □ Other (Specify) 22. Name and Address of Facility, Pritts Funeral Home 21. Signeture of Funerel Service Licanses and Chapel Ky. 412 Washington Pd 21157 Westminster MD 23e. Pert Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediate Ceuse (Finel disease or condition resulting in death) Esophagea potension Due to (or es e consequenca of): Status Post pardiopulmonary Resucitation 23b. Dfd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Ninknown alcohalic Liver 24b. Were autopsy findings evailable prior to completion of cause of deeth? 24e. Wes en eutopsy parformed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Yeer) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Neturel 5 Pending 1 Yes 2 No

Physician /Medical Examiner The law requires that the deeth certificate be executed

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To the Funeral Director: After thi
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P.O. Box 68760,

Division of Vital Records,

Physician:

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28a-f show

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7 is marked other than "natural", or items 23a or 28a-f show traumatic avant, the Medical Examine, must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite any finury or other traumatic avant, its Medical Example any finury or other traumatic avant, its Medical Example.

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Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest

Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I.

25. Was case referred to medical exeminer? 1 Yes 2 No

> investigation 6 Could not be 28e. Pleca of fnjury - At home, farm, street, fectory, offica building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)

2 Accident

4 - Homicide

3 ☐ Suicide

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due fo fhe ceuse(s) and menner es steled.
2 Medical Examiner: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, date end plece, end due fo the ceuse(s) end menner steled.

29b. Signature end title of cartified

29c. License number

29d. Date signed (Month, Dey, Year)

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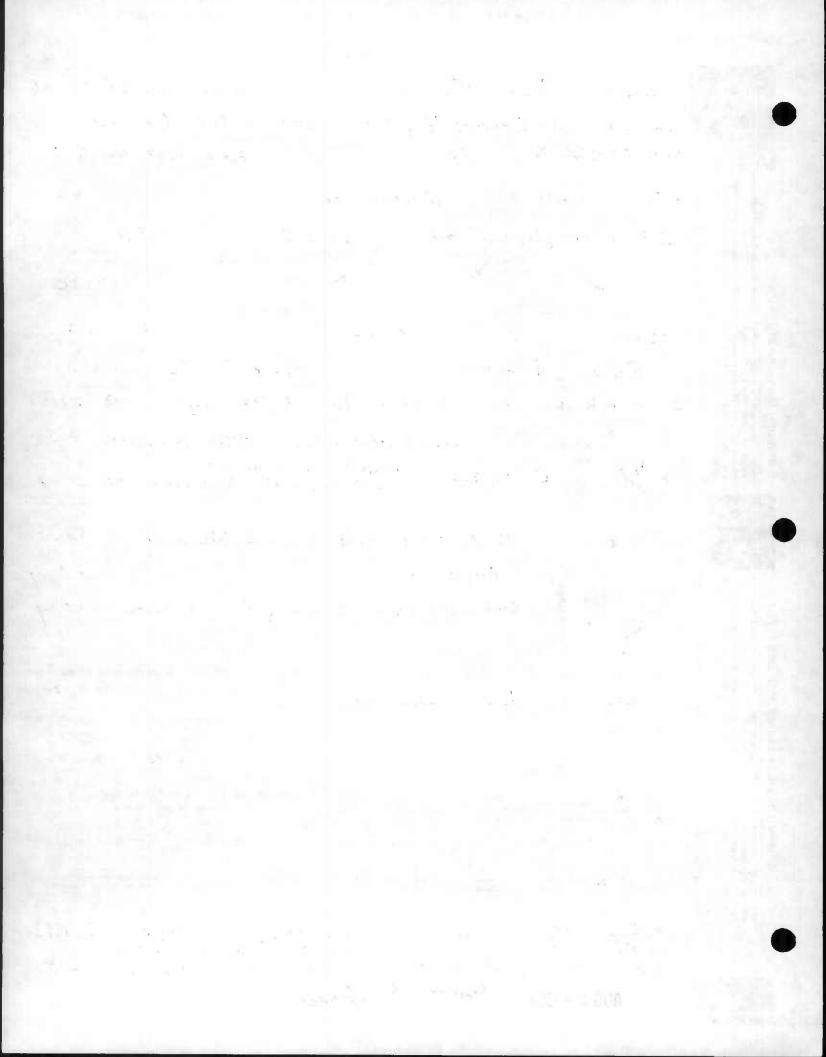
80052479

August, 18, 1998

30. Name end eddress of parson who completed cause of deeth (Item 23e) (Type, Print) LISA Kim, MD. at Carroll County at Hospita 200 memorzal General Avenue, Westminster, MD 21157

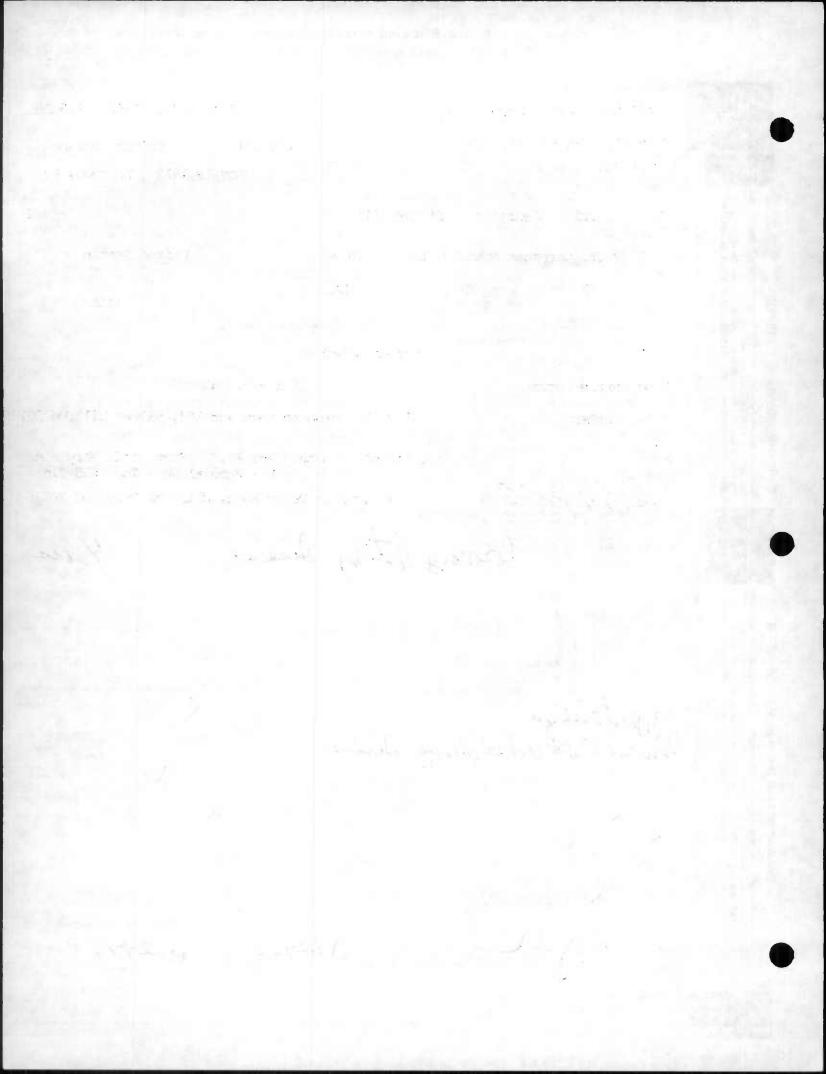
State Registrar

31. Dete filed (Month, Dey, Year) AUG 2 0 1998 32. Registrer's Signeture



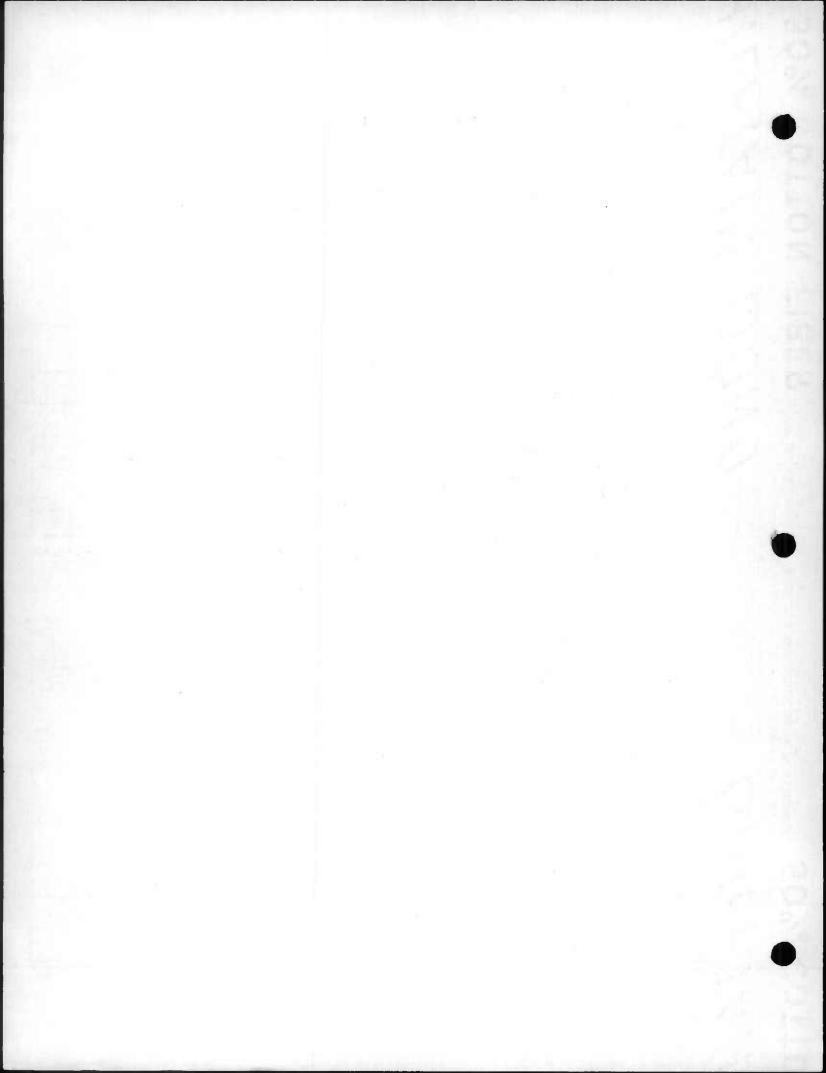
State of Maryland / Department of Health and Mental Hygiene 98 27239

							Certifica	te of	Death			Reg.	No.			
		1. Decedent's Name (First, M	liddle, La	st)		1	TALL				2. Date of Month	Death	Day	Vaar	3. Time of D	eath
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100	dical niner	4a Facility Name (If not instit	ution, giv	a street and n	umber)	•			4b. City, To	own, or Lo	ocation of D			y of Death	7 . 3 . 3 . 01	**
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ylan could be Mental	ToB	Amos Morris	Rutt	er					Liz	zie M	M. Bat	dor	£			
Maryland d 2 should be file th and Mental Hy 7 is marked oth traumatic event	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address						ss (Street	t and Numb	er or Rur	al Routa Nu	m <i>ber, C</i>	ity or Town	n, State, Zij	Code)	-
		Helen Rutter	r			38	49 St.	Barr	nabas	Road	d Apt	104	, Sil	ver H	ill,Md	207
re, N 1 and 1 Health tem 27		20a. Method of Disposition		5.00	20b	. Place of D	Disposition (N	ama of	200)		Date	20	c. Location	- City or To	own, Steta	
Baltimore bemit. Pages 1 a Department of He mportant: If Item iny Injury or othe		1 ☐ Burial 2 ☐ Cremati			n State		incoln			Λιιέτ	28 98	R.	rentw	Foor	Marylar	bo
Baltimo permit. Page Department of Important: If any Injury or		21. Signature of Funeral Sen			F	OI C II.							_	-	633 Old	
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requires that the death	Physician	Part II. Other algnificant con	ditions o	ontributing to	death but not r	esulting in t	he underlying	cause gi	ven in Part	I.	23b. l	Old toba	cco use c	ontributa t	o the causa of	death?
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Of Vita Physician: this certific ral director,	Be	25. Was cese referred to med examinar?	dicel	Hospital:		_		Ot	har		th (Check or		-			
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To To	Σ	29b. Signeture and title of cer	rtifier	1 4			2	ec. Licen	se number			29d	. Date sign	iea (Month	Day, Year)	
		N	1		_			1)	129	06		0	12	4/	4P	
		30. Name and eddress of par	son ho	completed ce	use of death (II	tem 23a) (T	ype, Print)		000	01.4	h 31	4	7	20725		
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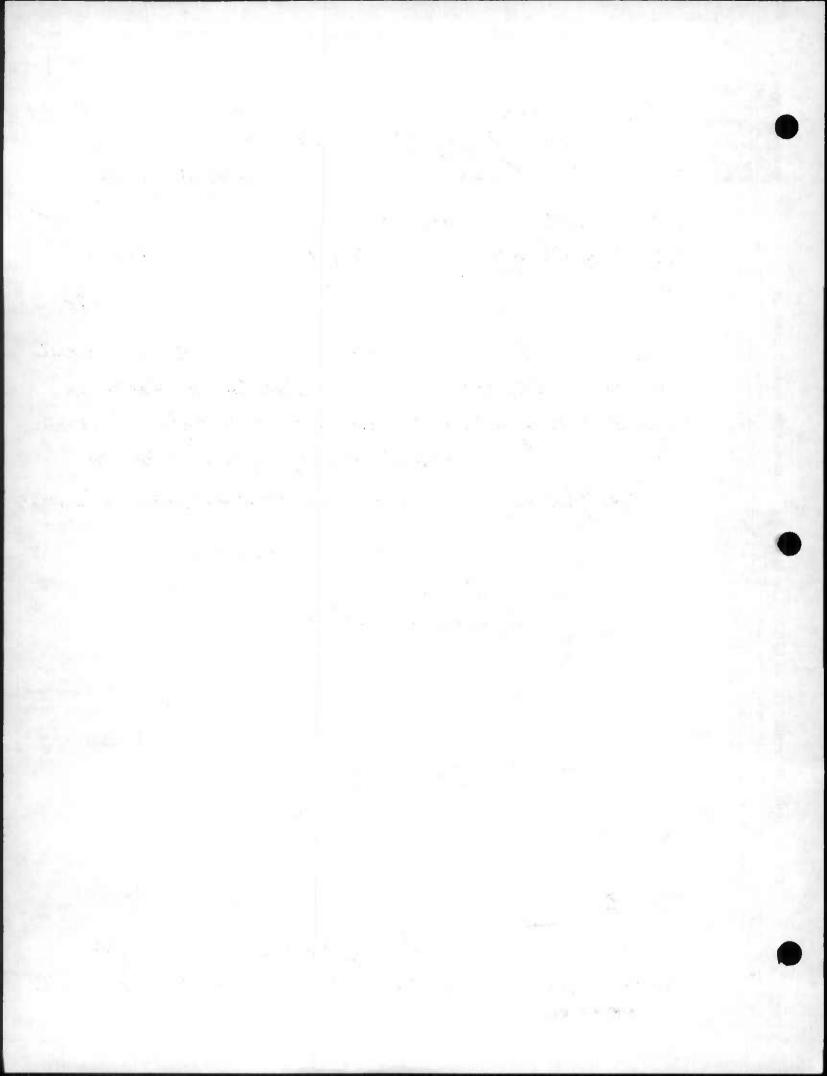
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	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within semicours after de	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the first surfain. The state within 72 hours after death with the State Deci. of Health and Mental Hydlene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical ex

	1 - FOR Item: 20b per F.HSTATE OF MARY REGISTRAR Item: 1per M.D G-767 1/20	LAND / DEPART	MENT OF HEALTH AND	MENTAL HYGIENE				
	1. DECEMENT'S NAME (First, Middle, Last) Hel	en R. Rath	erdale	2. DATE OF DEATH AU MONTH DAY	1998 39 "			
	577-03-9806 1 PM 2 0 F	82 YAS. "	IF UNDER 1 YEAR IF UNDER 24 HRS.	mn. (Month, Day, Year) 6 Country) C.				
TOR	98. FACILITY NAME (If not institution, give street and number) ST, Mary'S Northern Community RESIDENCE OF DECEDENT	enter	Sective, town or Location of	ow, Md &	c. COUNTY OF DEATH			
DIRECTOR	10a. STATE 10b. COUNTY St. Mary's	10c. CITY,	TOWN OR LOCATION HOllywood	•	10d. INSIDE CITY LIMITS? 1 YES 2 X NO			
FUNERAL	10a STREET AND NUMBER 24504 Clarks Landing Lane		101. ZIP CODE 20736		U.S.A.			
BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced 12. WAS DECEDENT EVER FORCES? 1 VE FORCES. 1 VE FORCES. 1 VE FORCES. 1 VE FORCES? 1 VE FORCES. 1 VE FORCE	S 2 NO	13. WAS DECENDENT OF HISP If yes, specify Cuban, Maxi 1 YES 2 N NO Spec	can, Puerto Rican, etc.)	No— 14. RACE — American Indian, Black, White, atc. Specify: White			
COMPLETED	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	life. Do NOT use	rk done during most of working retired.)	16b. KIND OF BUSINE	ESS/INDUSTRY			
MP	12 17. FATHER'S NAME (First, Middle, Lest)	Secret		Opticia				
	James Smallwood		Lula	AME (First, Middle, Malden Sun Smith	(lativa)			
8	19a. INFORMANT'S NAME (Type/Print)	19b. MAILING A	ADDRESS (Street and Number or Run		State, Zip Code)			
5	James F. Ratherdale/Son	15323	Endicott Drive	, Bowie, Mary	yland 20716			
	20e, METHOD OF DISPOSITION 1 Burial 2 Cramation 3 Removal Iron Disposition	PLACE OF DISPOSIT	TION (Name of cemetery, crematory of	8/25/98 20c. LOCAT	TION — City or Town, State			
	4 Denetion of Other (Specify)	Irinity M	emorial Garden	s Wald	dorf, Maryland			
	1000 13 1 30VI	00053	THE HUNTT FU P.O. BOX 156	JNERAL HOME, S, WALDORF, M	INC. MARYLAND 20604			
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	S A CONSEQUENCE OF)	1. 1		Onset and Deeth			
PHYSICIAN: MEDICAL CE	PART II. Other algnificent conditions contributing to deets Chronic Disspurch	but not resulting in	the underlying ceuse given	Part I. 24a. WAS AN AUTPERFORME	D? AMPLABLE PRIOR TO			
AN	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEATH (Check only one)				
SICI	EXAMINER? 1 YES 2 NO 1 inpetient 2 ER/0		OTHER:					
ВУ РНҮ	27. MANNER OF DEATH 1 Netural 5 Pending (Month, Day, Yea 2 Accident investigation	Y 20b. TIME	OF 28c. INJURY AT WORK? M 1 YES 2 NO	28d. DESCRIBE HOW INJU	JRY OCCURED			
		JRY — At home, farm, st specify)	reet, factory, office	28f. LOCATION (Street and City or Town, State)	Number or Rural Route Number,			
COMPLETED	29a. CERTIFIER (Check only one) 1 DERTIFYING PHYSICIAN: To the bast of my kn one) 2 MEDICAL EXAMINER: On the bast of examine							
TO BE CO	295. SIGNATURE AND TITLE OF CERTIFIER	M	29c. LICENSE N	230 21	9d. DATE SIGNED (Month, Day, Year)			
-	DAVID ALLEN MD	115 Wash	1 00	aard town	MD 20650			
	31. DATE FILED (Month, Dey, Year) AUG 2 5 1998 32. REGISTRAR'S'S		books					



State of Maryland / Department of Health and Mental Hygiene

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Dhualaian		1. Decedent's Name (First, Middle, Lest)					2. Date of Death Month	Day	3. Time of De										
Physician Medical/		MARY REIS	LER				Aug. 10,	1998	12:20 A										
Examiner		4a. Facility Name (If not institution, give si	treet end number)		4b. Cit	y, Town, or Lo	cation of Deeth	4c. County	of Death										
		CALVERT MANO.	e NUISIN	19 Hom	e R	151NG.	SUN	(ecil										
uneral		5. Social Security Number 6. Sex	7. Age (In yrs			nder 24 birs. urs Min.	8. Date of Birth (Month, Dey,	Vees)	9. Birthplace (Stete or F										
irector		221-17-1331	M 20 8 6	Yrs.	luis buys 110	OIS WILL.	12/26/19	//	Country)										
* =		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Location			, ,		10d. Inside City L										
28a-f ahow notified at	0	mo Cecil	F	PISING SI	111				1 ☐ Yes 2										
289	Director	10e. Street and Number			. Zip Code		10	g. Citizen of W	/het Country?										
Evantine injustice notified at the Property of the Political at the Political at the Political Director.	5	1881 Telegraph	Rn.	/	71911			_	ISIA.										
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J. 0	2	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 □ Ye	s 212 No Spe	ecify:		Specify:	WHITE										
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d other		17. Father's Name (First, Middle, Last)			18. N	Aother's Name	(First, Middle, M	laiden Sumeme	9)										
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Y 0 1		1 Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	cemetery, cremetory	Cemeter	1 8	1/13/98	OX For	I Pr										
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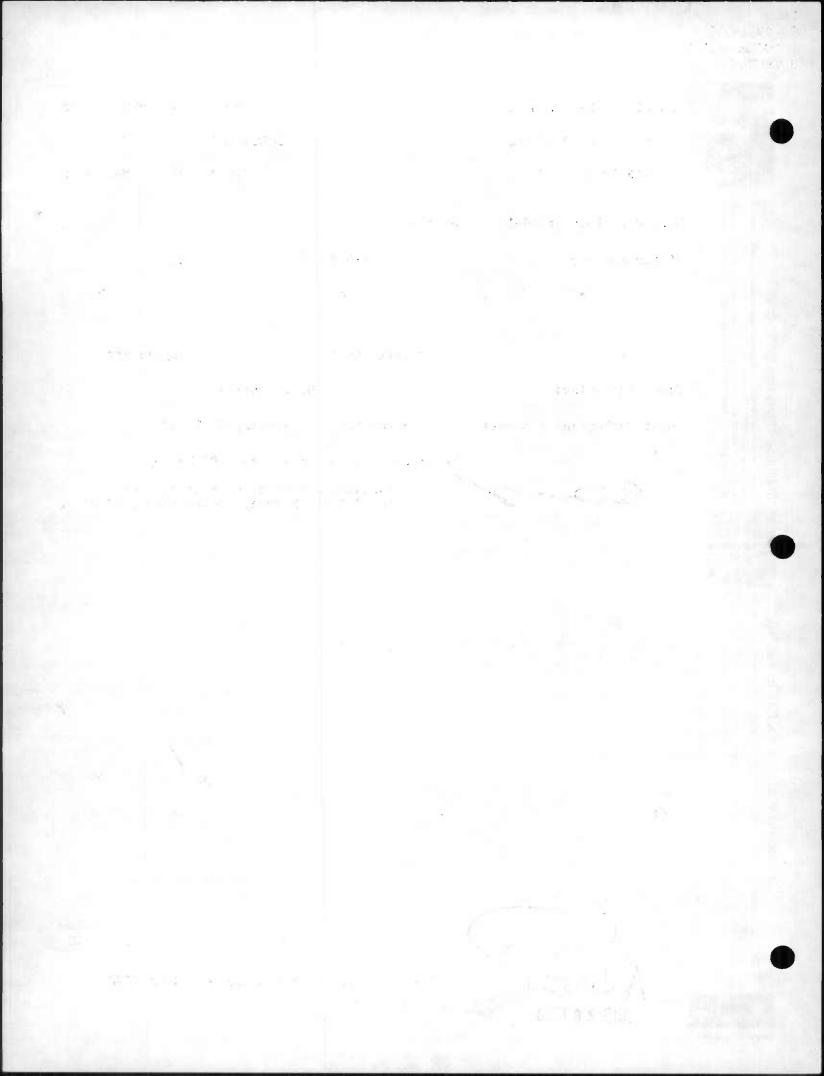
111 Penn Street, Baltimore, Maryland 21201

State Registrar 31, Date field

Di

AUG 2 6 1998

32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Time of Deeth P 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 18:10 m **Physician** Elsie Elizabeth STOTTLEMYER aug /Medical 4e Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Hagerstown Washington County Hospital If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplece (Stata or Foreign Country) **Funeral** Months 1 □ M 2 X F Yrs. Oct. 16, 1920 West Virginia Director 77 219-14-8343 Usual Rasidance of Dacedeni the Marylend 10a Stata 10b. Count 10c. City. Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yas 2X No Directo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? with 16863 Shinham Road 21740 Pages 1 and 2 should be filed within 72 hours efter death vent of Haalth end Mental Hygiene. nt: If them 27 Is marked other than "natural", or thems 23. Funeral 14. Race - American Indian. 12. Wes Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxicen, Puarto Rican, etc.) Bleck, Whita, atc. 1 Yas 2 No If Yes, Giva Yaar or Detas: 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 "natural", or 1 Yas 2 No Specify: white þ 3 ☑ Widowad 4 ☐ Divorced or than "natura". Completed 16a. Decedant's Usuel Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Spacify only highast grada completed) Elementery/Secondary (0-12) Collaga (1-4or 5+) her own home housewife 7 is marked other traumatic event, i 18. Mother's Neme (First, Middle, Maiden Sumama) 17. Fethar's Nama (First, Middla, Last) Ella Lillian Anderson Horace Renner 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Shirley Pryor - daughter 610 Frederick St., Apt. 2, Hagerstown, Md. 21740 Item 27 20b. Place of Disposition (Nema of cematary, cramatory or other place) 20c. Location - City or Town, Stata Important: If the any injury or oth 1X Burial 2 ☐ Crametion 3 ☐ Ramoval from State 8-27-98 Hagerstown, Maryland Rest Haven Cemetery 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatura of Funeral Sarvice Liceny 22. Nama and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset end Deeth **Physician** Immediata Causa (Final disaase or condition resulting in death) /Medical 2MONTHS COLON CARCINOMA. Examiner Due to (or as a consequence of): Examiner LIVER METASTASIS 2 MON 7 HS attending physician and for use as the burial-transit tha death certificate be axecuted Sequantially list conditions, if any, laading to immadiata ceusa. Entar Undarlying Cause (Diseese or Injury that Initiated evants rasulting in daath) Last Dua to (or es a consequence of): PNEUMONIA IDAY. Physician/Medical Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No nousþ 24b. Wara autopsy findings eveilable prior to completion of cause 24a. Was en autopsy Completed has page 2 2/1 No 1 Yas 2 No certificate 25. Was cesa rafarred to madicei axaminar? director Be 26. Placa of Daath (Check only one) To Hospital: 1 ☑ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yas 2 No Othar: 4 Nursing Homa 5 Rasidance 6 Other (Specify) this funeral 28a. Data of Injury (Month, Dey Year) 27. Menner of Daeth 28b. Time of Injury 28d. Dascribe how Injury occurred 28c. Injury at Work? Certification: Attending 1 Neturel 5 Pending invastigation NIA 1 ☐ Yas 2 ☐ No death. NA WIA 2 Accidant ector: 6 Could not be datarmined 3 Suicida 28a. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) à Direc 4 Homicide ò To the Hospital or within 24 hours aft To the Funerel Diccompletely filled in 29a. Cartifiar 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the causa(s) and manner es stated. edical (Check only one) 2 Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, death occurred et the time, data and place, and due to the cause(s) and manner stated. 29b. Signature and titla of certifian 29c. License number 29d. Deta signed (Month, Day, Year) 028365 24.90. 30. Nama end addrass of person who completed ceuse of death (Itam 23a) (Type, Print) STREET HAGERSTONN HAFI. 368 MILL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Derew AUG 2 5 1998

DHMH 16 Rev 6/95

Registrar

stattlemyer, Elsi

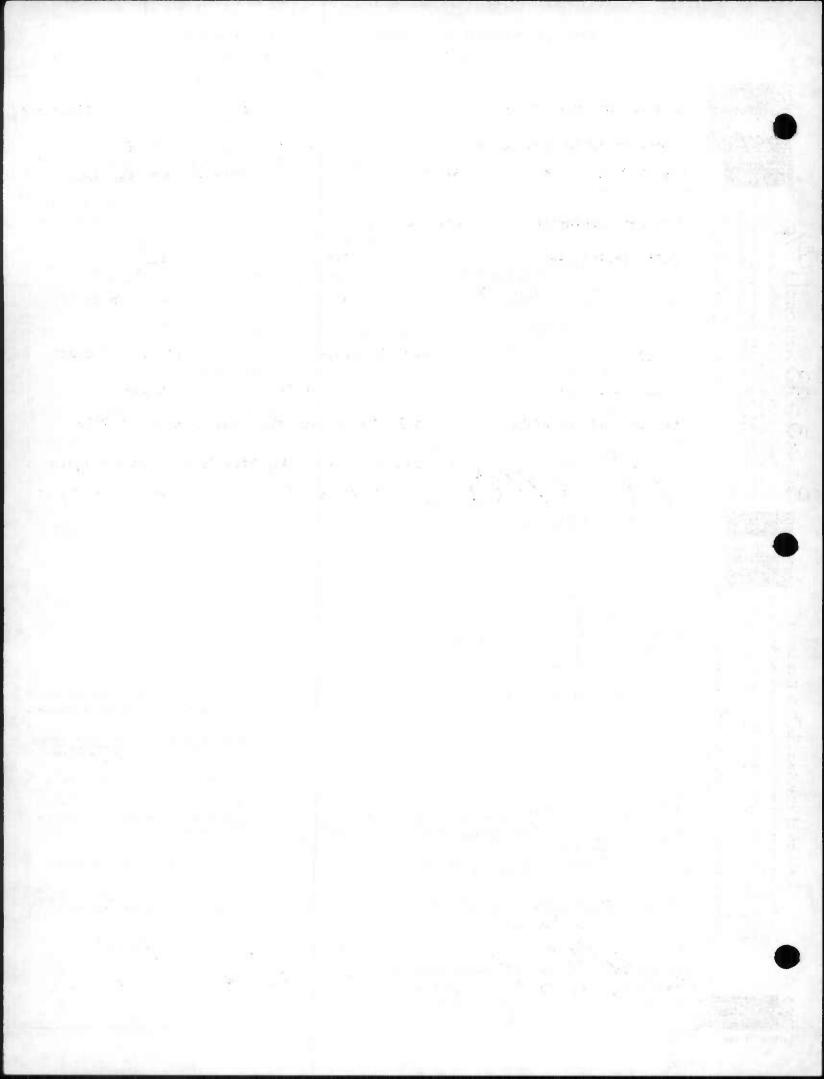
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Dev **Physician** Milton Roosevelt Smith August 23,1998 11:05 P.M. /Medical 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Homewood Retirement Center Williamsport Washington 8. Dete of Birth (Month, Day, Year) Dec 14, 1904 6. Sex 1X M 2□ F If Under 1 Year Months Deys If Under 24 Hrs. Hours Min. 5. Sociel Security Number 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) **Funeral** Months 219-12-2160 Director 93 Maryland Usuel Residence of Decedent 10c. City, Town or Location item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic avant, the Modical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 X No Director Maryland Washington Williamsport 10e. Street end Number 10f. Zlp Code 10g. Citizen of Whet Country? 16505 Virginia Ave. 21795 USA 12. Wes Decedent Ever In U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status 14. Rece - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Yeer or Detes: . 00 1 ☐ Never Merried 2 ☑ Merried 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pagas 1 and 2 should be filed within 1 Department of Health and Mental Hygiane. Important: If tem 27 is marked other than "n any Injury or other traumatic avant Eiementery/Secondary (0-12) College (1-4or 5+) Owner/Operator Petroleum Products 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be John Henry Smith Ella 0 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Barbara Miller/Per.Rep. 8722 Downsville Pike Williamsport, MD 21795 20b. Pleca of Disposition (Neme of cemetery, cremetory or other piece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Smithsburg Crematory Aug 24,1998 Smithsburg, Maryland 21. Signature of Funerel Service Licensee 22. Name end Address of Fecility Osborne Funeral Home 425 S. Conococheague St. Williamsport, MD 21795 cara 23a. Pert1. Enter the diaduse, of complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting In deeth) /Medical 000016 Examiner Due to (or es e consequenca of) Examiner physician and s the burial-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Couse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of). Physician/Medical Due to (or es e consequença of): for usa as Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? tha datached 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings evellable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed has YOU TU certificata 1 Tes 1 ☐ Yes 2 ☐ No s case referred to medical 25 Was Be 26. Piece of Deeth (Check only one) 1 Yes 2√ No Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) P After this funaral 27. Menner of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury et Work? 28d. Describe how Injury occurred 1 Natural 5 Pending Investigation after death. 1 Yes 2 No 2 Accident Director: 8 Could not be determined 3 Sulcide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Straet end Number or Rural Route Number, City or Town, Stete) 4 - Homicide ò 24 hours s **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

**Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. Medical 29a. Certifier plataly (Check only one) To the I vithin 2 To the I complet 29b. Signature and title of pertition 29c. License number 29d. Dete signed (Month, Dey, Year) D26806 Neme and didness of person who completed cause of deeth (Item 23e) (Type, Print) And Hajarten mo

State Registrar 31. Dete filed (Month, Day, Year)

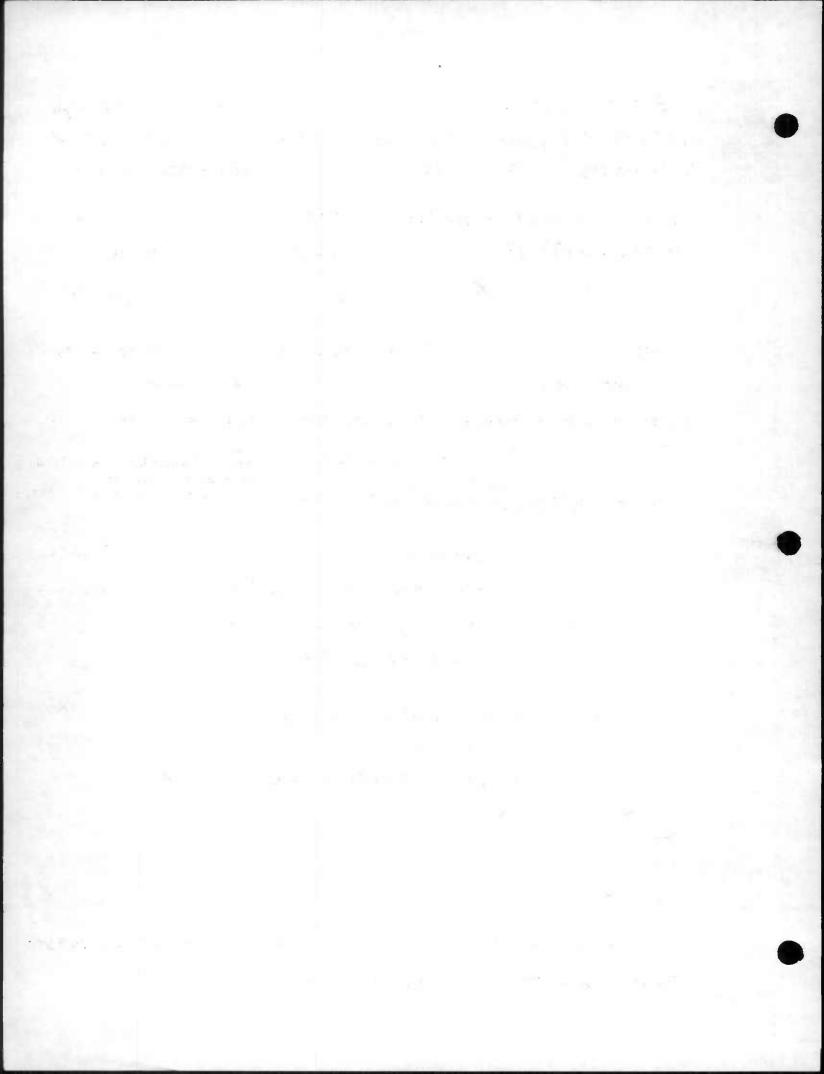
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32. Registrar's Signeture



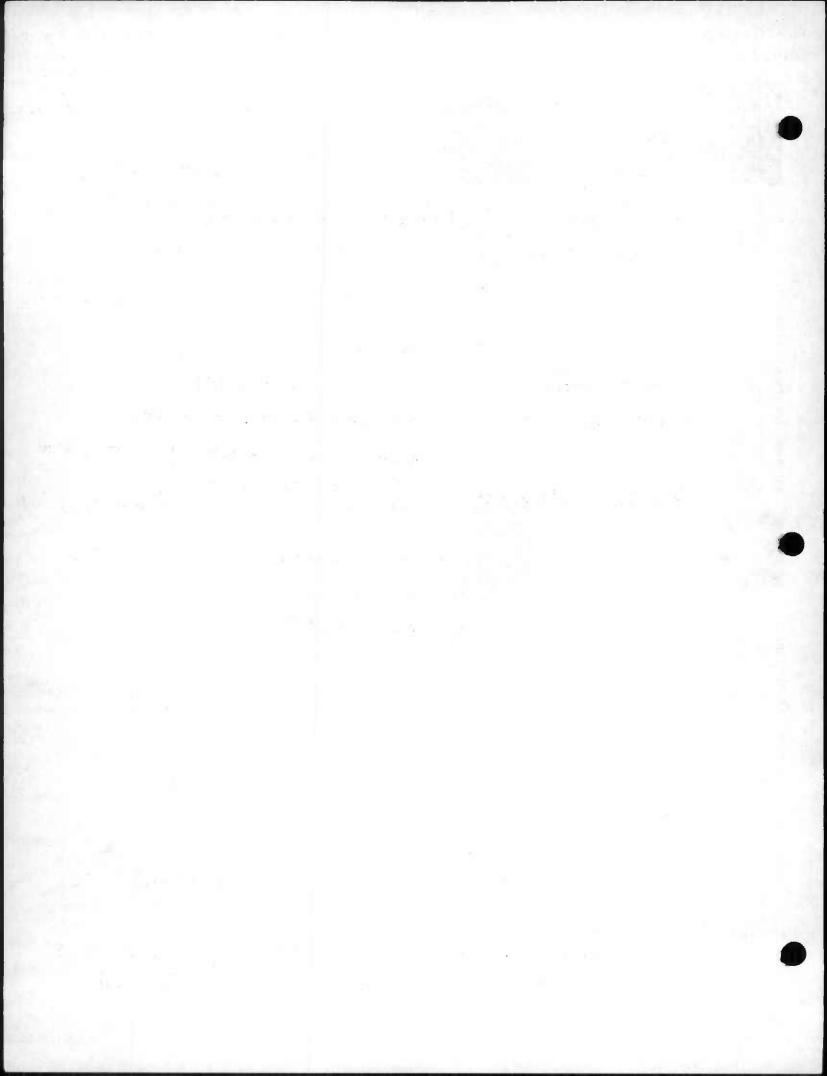
State of Maryland / Department of Health and Mental Hygiene 98 27245

					Cer	tificate of	Death		Reg. No.		
	Physici /Medi		1. Decedent's Name (First, Middle, L EHHA	SEHLER				2. Date of De Month	eath Day	Year / 9 8	3. Time of Death
	Examir		4a. Facility Name (If not institution, g		SPITA	42	4b. City, Town, or HABER	STOWA	h 4c. Count	y of Death	STON
	Funeral Director			Sex 1 M 2 F 7. Aga (In yrs	lest birthday)	If Undar 1 Yaa Months Days			, 1921	9. Birthp	place (State or Foreign ntry) inois
	he Maryland 8a-f show offined at	ector	10a. State 10b. County WASHI.	NGTON HA	ty, Town or Loc	STON	N				0d. Inside City Limits
	ath with the 23a or 2	Funeral Director	10e. Street and Number 409 LIBER	ty st.		10f. Zip Coda 217	40		10g. Citizen of	What Coun	itry?
020	72 hours after death with the Maryland natural; or Items 23s or 28s-1 show deal Examiner must be notified at	by	11. Marital Status 1 Never Marriad 2 Married 3 Widowed 4 Divorced	12. Was Dacedent Ever in U Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Give Year or Dates:		/as Decedent of Yes, specify Cu ☐ Yes 20 No	Hispanic Origin? (5 ban, Mexican, Pual o Specify:	Specify Yes or No to Rican, etc.)		ce - Americ ck, White, fy: L/H	atc.
21215-0020	within ene. than °	Completed	15. Decedent's (Specify only highest g Elementary/Secondary (0-12) 0-12	Education rede completed) College (1-4or 5+)	(Give k	ent's Usuai Occu cind of work done O NOT use retir	e during most of wo ed)	orking	16b. Kind of B		th Dept.
Maryland 2	should be filed with nd Mentel Hygiene. marked other than imatic event, the M	To Be Co	17. Father's Name (First, Middle, Let	craro			18. Mother's Na	me (First, Middle Anna		me)	
	2 sh end la m		19a. Informant's Name/Relationship Mr. Ernest T. Ser				Street,				,
altimore,	Pages nent of int: If it		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Special Content of the Content	Ramoval from State		ition (Neme of etory or other pl Cemete		Aug. 26 1998	20c. Location		own, State Maryland
Ba	pemit. Departrimports any inju		21. Signature of Funaral Sarvice Llc	Minu	1	Name and Add	,		Funera erstown		ne yland 2174
	Physician /Medical Examiner		23a. Part1. Enter the disease, or co shock, or heart feilure. List on Immediate Cause (Final disease or condition resulting in death)	aPnus	th. Do not anta Monotorial or as a consequ		ring, such as cardie	c or raspiratory a	irrast,	2	Approximata Intervel Between Onset and Deeth L WKS.
Box 68760,	law requires that the death certificete be executed as been signed by the ettending physician end a 2 should be detached for use as the bunel-transit	in/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initiated events resulting in daath) Last	Due to (End	estive or as a consequence or as a consequence chellese	Hearienca of): Ren ance of): mel	nt Fan al Drs Untres	line			ynlenown
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Vital Re	The ate h	Be Com	Sev-C	re Periphia	e vas	cular.		1 □		10	☐Yes 2☐ No
ō	Attending Phys or death. ector: After this by the funerel di	Certification: To E	examiner? 1 Yes 2 No 27. Manner of Death	28e. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. Inj W M 1[ther: 4 Nursing ury at ork? Yes 2 No	Home 5 Res 28d. Describe	idence 6 🗆 Oti how Injury occu	rred	iy) al Routa Number,
_	To the Hospital or within 24 hours efte To the Funeral Diracompletely filled in	edical Ce	29a. Certifier (Check only one) Certifying F 2 Medical Exe	hysician: To the best of my kniminar: On the basis of examina	owiedge, death ation and/or inve	occurred et the estigetion, in my	time, dete and plac opinion, death occ	e, and due to the urred at the time,	cause(s) end m date and placa,	anner es si , and due to	taled. the cause(s)
	To the within To the comple	Mec	29b. Signature and title of certifier	and manner stated.			nse number 44996		29d. Date signed Augus		
			30. Name and eddress of person who ZAFAR MAIK	completed cause of death (Item, MD 2031)	m 23a) (Type, P	erint) NS RD	Coors Box	ZO MO	2/7	13	-, 1998.
	Sta Registr		31. Date filed (Month, Day, Year) ALG 25	32. Registrar's Sign	dature 4.	Span	Ke				



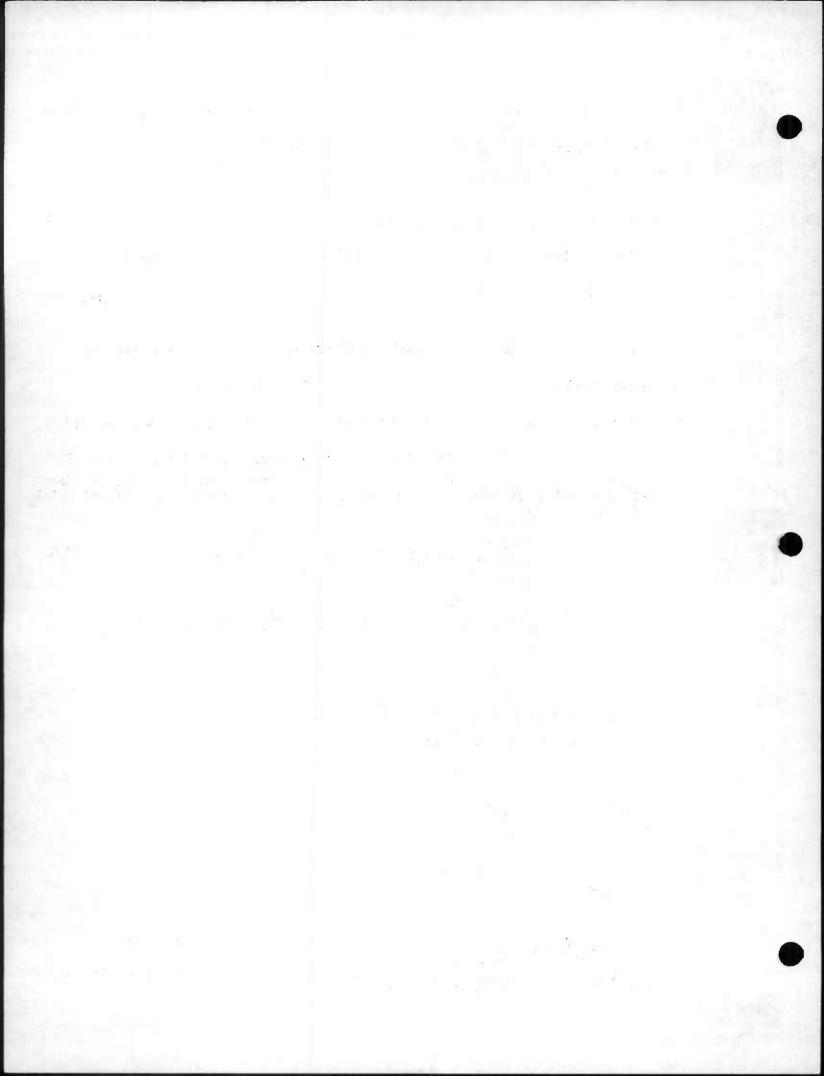
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		7	1. Decedent's Neme (First, Middle, Last)	2. Dete	Reg. No.	3. Time of Deeth			
	Physic /Medi		Mary Hannah Snider	Augu		1998 12:20 p.m			
j.	Exami			ity, Town, or Location of gerstown		ty of Deeth hington			
	Funeral Director		220-22-8104 1 M 2展F 73 Yrs. Months Days H	Under 24 Hrs. 8. Dete lours Min. 11-	of Birth off, Dey, Year) 06-1924	9. Birthplace (State or Foreign Baltimore, Md.			
Ŧ	wo m		Usuel Residence of Decadent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits				
	a-f sh	ctor	Pa. Adams 677 Upper Temple RP.	, Biglervil	lle	1 ☐ Yes 2 No			
	ath with the	Funeral Director	10e. Street end Number 10f. Zip Code 17307		USA	Whet Country?			
020	n 72 hours efter death with the Manylen "natural", or items 23a or 28a-f show edical Examinator notified	by	11. Marital Status 1 □ Never Married 2 □ Merried 3 ☒ Widowed 4 □ Divorced 12. Wes Decedent Ever in U,S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Sixe Year or Dates: 13. Wes Decedent of Hisper If Yes, specify Cuban, M 1 □ Yes 2 ☒ No If Yes, Sixe		s or No- ltc.) 14. Re Bi	ace - American Indien, eck, White, etc. ify: White			
21215-0020	- m	Completed	15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 16e. Decedent's Usuel Occupetion (Give kind of work done durin life. DO NOT use retired) Housewife	ng most of working		Business/Industry			
d 2	be filed with ttal Hygiene. d other than event, the	Be Co		Mother's Name (First, I	Home me (First, Middle, Meiden Surneme)				
ylar		ToB	John Q. Andrews	Helen Por	well				
Σ	od 2:		19e. Informent's Neme/Relationship (Type, Print) Richard R. Snider 19b. Mailing Address (Street and 3049 Buchanan R		na, Pa. 17	353			
Baltimore,	permit. Pages 1 en Depertment of Heeli Important: If item 2 any injury or other once.		20e. Method of Disposition 1	Dete 8-25	M11	en Twp., Adams Pa.			
68760,	beath certificate be executed the composition of the composition and the composition of t	n/Medical Examiner	and Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, su shock, or heart feilure. List only one cause on each line. Immediate Cause (Finei disease or condition resulting in deeth) But to (or es e consequence of): Mul Tiple Tripura Due to (or es e consequence of): Motor Value Accionations, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that Initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of):	bere	etory errest,	Approximate Intervel Between Onset and Death			
.0	death	Physician/M	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in	Pert I. 23I	b. Did tobacco uee c	ontribute to the cause of death?			
о. О	thet the dered by the e				1 □ Yes 2 No	3 Probably 4 Unknown			
	aw requires s been sign 2 should be	Completed by		248	a. Wes en eutopsy performed?	24b. Were eutopsy findings eveileble prior to completion of cause of deeth?			
<u> </u>	The ete h page	Con			1 ☐ Yes 2 No	1 ☐ Yes 2 ☐ No			
\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	Physician: The this certificate ral director, pag	o Be	exeminer?	. Plece of Death (Check		4.1.10			
o	ding Phys h. After this funeral d	n: To	27. Manner of Deeth 28e. Date of Injury 28b. Time of 28c. Injury et	Varsing Home 5 28d. Des	scribe how injury occu				
Sior	Attending ir deeth. ector: After by the fune	atlo	2 Accident Investigation Aug 7 99 12; 20 M 1□ Yes	2500 He		ellisky			
	i or Attend efter deeth Director: / d in by the f	Certification:	3 Suicide 6 Could not be determined 28e Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)	28f. Loca City	or Town, Stete)	To was kip			
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	To the H within 24 To the Fi complete	Medical	one) and menner steted.						
	P ₹ P 80		29b. Signeture end title produits 20c. License nur D 1/2		290. Date sign	ned (Month, Dey, Year)			
			30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)	0	1	- 11			
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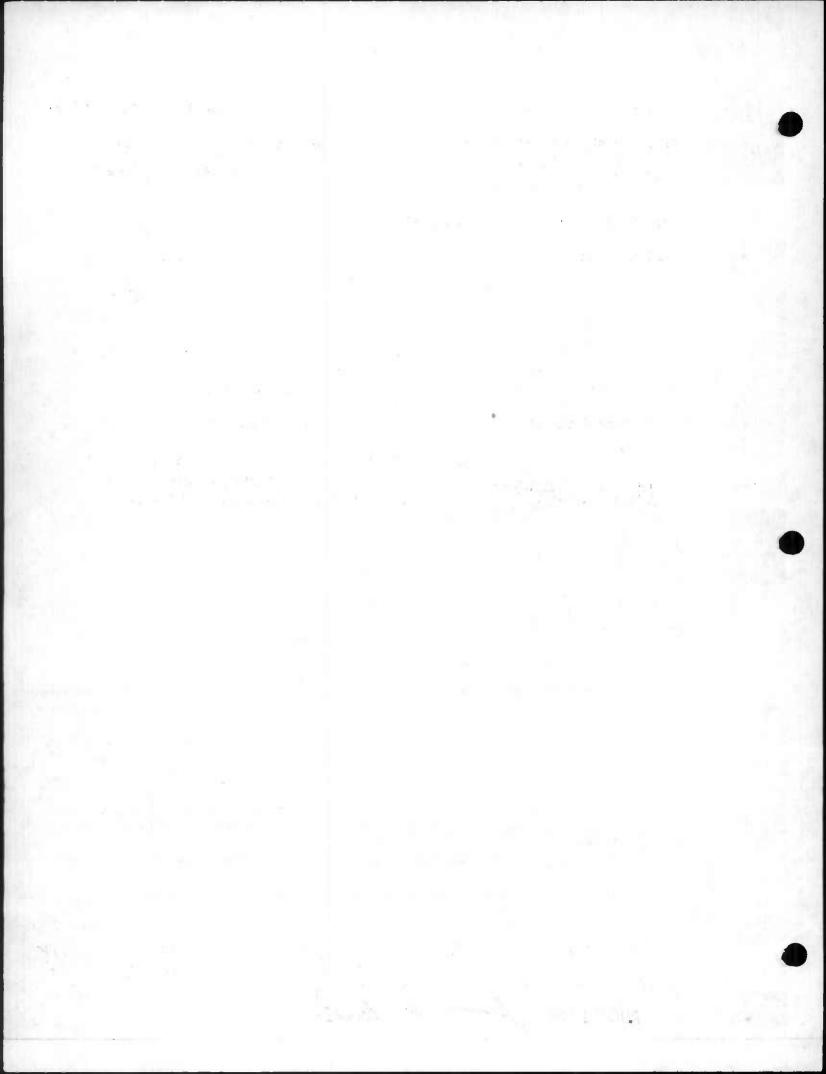
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Physici /Medi Examir	cal	Pauline Beverl 4e. Fecility Name (If not institution,				4b. City, Town, or Lo	Month August	20 196	7ear 98 /8:00
Funeral Director	ner	Carroll County G 5. Social Security Number 124-10-0530	eneral Hosp	ital a (In yrs. lest birtho 78 Yr	day) If Under 1 Yaar	Westmins	ter	Carı	
MO TO		Usual Residence of Decedent 10e. State 10b. County		10c. City, Town o	or Location				10d. Inside City L
Paris Paris	ctor	Maryland Carrol	1	New Wind	dsor				1 □ Yes 2
0r 28	Directo	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	at Country?
f, or items 23.	y Funeral	3700 Sams Creek 11. Maritel Status 1 Never Married 2 Marrie 3 Widowed 4 Divorcad	12. Was Decedent E Armed Forces? d 1 Tyes 2 N If Yes, Give		21776 13. Was Dacedent of Fif Yas, specify Cubin 1 Yes 2 No	dispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)	Black,	American Indian, White, etc.
yyene: the than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	Completed by	(Specify only highest Elementary/Secondary (0-12)	Year or Dates: Education grede completed) College (1-4or 5-	+)	ecedent's Usual Occup live kind of work done fe. DO NOT use retired	pation during most of work d)	ing	16b. Kind of Business/Industry State Hospital	
	BeC	17. Father's Name (First, Middle, Le		110.	. 50	18. Mothar's Neme	e (First, Middle,	Maiden Sumame)	A
marked o	ToE	Jesse Jackson				Gladys 1			
7 fs me traum		19a. Informant's Nema/Relationship			lailing Address (Street				
Important: if item 27 is marked other any injury or other traumatic event, once.		Dawn Peacock/dau 20a. Method of Disposition 1 Burial 2 Cramation 3 4 Donetion 5 Other (Spe	☐Ramovai from State	20b. Placa of Di cematery,	5 Tall Pine isposition (Neme of cremetory or other plea	ca)	Dete 3/24/98	20c. Location - Ci	ity or Town, State
Important any injury once.		21. Square of Funeral Service Li			Cremation 22. Name end Addre 310 Church	ess of Facility Ha	rtzler	Hampste Funeral	Home
edical aminer street transit	edical Examiner	Immediate Ceuse (Final disease or condition resulting in death) Sequentially list conditions, if any, leeding to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest	b	Due to (or as a con		athy			Iday
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detach							101	res 2□No 3	□ Probably 4 © Un
has been signed l ge 2 should be det	Completed by						24e. Was o	en autopsy med?	24b. Were eutopsy find availeble prior to completion of caus of death?
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fter this	2	25. Was case referred to medical examiner? 1						ne) lence 6 Dother low Injury occurred	
al Director: A led in by the fu	Certification:	2 Accident Investigat 3 Suicide 6 Could not determine	M 1 □ street, fectory, office	Yes 2 □ No	28f. Location (S City or Tow		or Rurel Route Number		
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the Fune pletely fil					29c. License	e number	2	29d. Date signed (I	Month, Dey, Year)
To the Funeral C	Σ	29b. Signature and title of certifier Signature and eddress of person wh	in m	. D	Dan	52470)	august	20. 190

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Item 20b, Per F.D. 8/28/98, Carroll County, wil Certificate of Death 3. Time of Death 2. Date of Deeth **Physician** UNACIES EDYVITA
4a Facility Name (If not institution, give street and number)

(Aunty Chneval det birthd EDWARD SIES 1998 10:10 Am August /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Westminster HOSP Carroll County If Under 24 Hrs. 8. Date of Birth If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 14864 1 10 M 2 □ F Director Usual Residence of Decedent with the Marylend 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ M6 Funeral Director 10g. Citizen of What Country? 10e. Street and Ny Framehor must be Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No 1 Yes, Give Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Maritel Status Black, White, etc. 1 Never Married 2 Married Yes, Give Yeer or Detes: WWII Specify: 3 ☐ Widowed 4 ☐ Divorced the Medical E Be Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) MECHANI of mand should be EDWAPD SIES 19b. Mailing Address (Street and Number or Rural Royte permit. Peges 1 and 2. Department of Health er Health em 27 I 120/98 Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cha FUNERAL HINGTON RD 23a. Part 1. Enter the 2 sease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Ceuse (Final disease or condition resulting in death) chiceage! 2 urone /Medical Examiner Due to (or as a consequence of): Physician/Medical Examiner that the deeth certificate be executed physician and s the buriel-trans Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): P.O. Box 68760, Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. þ 24b. Were eutopsy findings eveilable prior to 24a. Was en eutopsy performed? Completed completion of cause of death? certificate has b lirector, page 2 s 2 No Be 25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Mnpatient 2 □ ER/Outpatient 3 □ DOA 27. Manner of Deeth 28d. Describe how injury occurred Certification: Attending Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours after the Funeral Directles Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as steted.

2 Madical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier (Check only one) To the To the Comple 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) who completed ceuse of death (Item 23a) (Type, Print) Memprial 200 minJth, Registrar AUG 2 0 1998

DHMH 16 Rev 6/95

9822302460 UNIT # 22-09-26 SIES. CHARLES EDWARD JR *57-8 SIMPSON, HELEN E 10/19/1923 M 08/11/09

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. FOUND 3. Time of Death 05:15 PM 1. Decedent's Name (First, Middle, Last) 2. Dete of Death SEGER 24, MARY NICOLL AUGUS FOUND 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street and number) 4c. County of Death CEDARVILLE BRANDYWINE ROAP PHINCE GEORGES 10505 If Under 24 Hrs. If Under 1 Yeer 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) Months Hours Deys Yrs 218 14 2876 82 Dec 4, Ohio Usual Residence of Decedent 10b Count 10c. City, Town or Location 10d Inside City Limits 1 ☐ Yes 2 ☐ No P.G. Brandywine 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code 10505 Cedarville Road 20613 United States 12. Wes Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Yeer or Detes: 1 ☐ Never Married 2 ☐ Married 1□ Yes 2□No Specify Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Administrative Federal Government 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Francis Nicoll Mary Burns 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Shelly Coller 11932 Montgomery Lane, Waldorf, Md 20602 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Aug 28, 1998 20e. Method of Disposition 20c. Location - City or Town, Stete 1X Surial 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) Immanuel United Methodist Cemetery Brandywine, Maryland 22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old 21. Signature of Funeral Service Licenses Alexandria Ferry Road, Clinton, Maryland 20735 Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, about, or ment feilure. List only one cause on each line. Approximete Intervel Between Onset end Death Immediate Cause (Finel . HYPERTENSIVE ARTERIOSCUEROTIC CARDIOVASCULAR DISEASE diseese or condition resulting in deeth) Due to (or es a consequence ot): Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence ot): Due to (or es e consequenca of). Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yss 2 ☐ No 3 Probably MELLITUS 24b. Were autopsy tindings evailable prior to 24a. Wes en eutopsy performed? completion of cause of death? 2000 1 Yes 1 ☐ Yes 2 ☐ No 26. Placa of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examina

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After Attending

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To the Hospital o within 24 hours at To the Funeral D

Box 68760

Division of Vital Records, P.O.

and

Physician

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Examiner

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Funeral

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7 is marked other than "natural", or itema 23s or 28a-f show treumstic event, the Medical Experient must be notified at

I Hygiene.

permit. Pages 1 and 2 should be illed with Department of Health and Mental Hygien, important: if item 27 is marked other the any injury or other treuments.

the Maryland

death

72 hours after

Baltimore, Maryland 21215-0020

Examiner Physician/Medicai p Completed Be Certification:

DIABETES

25. Wes case reterred to medical 1 Yes 2 No 27. Menner of Deeth

5 Pending investigetion

6 Could not be determined

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year)

28b. Time of

28c. Injury et Work? 1 ☐ Yes 2 ☐ No 28e. Pleca of Injury - At home, ferm, street, fectory, offica building, etc. (Specify)

28d. Describe how injury occurred

DRIVE, CHEVERLY

Location (Street and Number or Rural Route Number, City or Town, Stete)

(Check only one) 29b. Signature an

1 Neturel

2 Accident

3 Suicide

29a. Certifier

4 T Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end menner stated.

29d. Date signed (Month, Day, Year)

PIME 30. Name and address of person who admpleted cause of de ath (Item 23a) (Type, Print) 3001 GOLKE

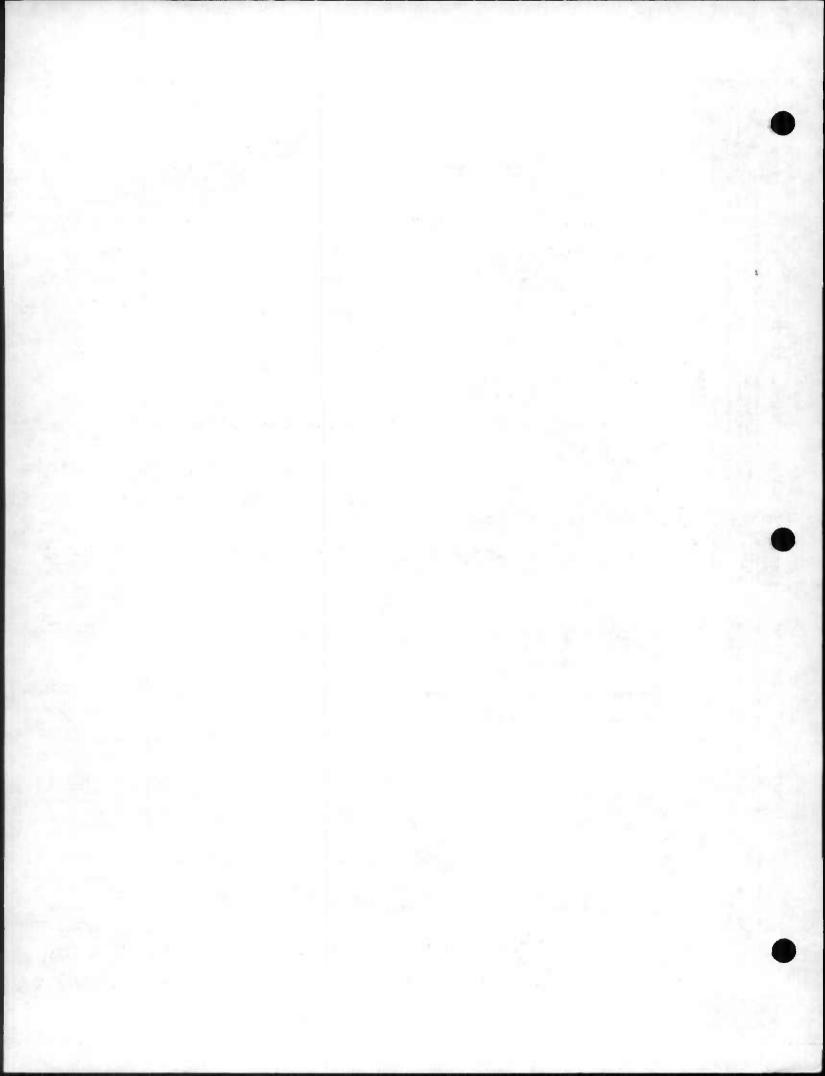
MARIO 31. Dete tiled (Month, Pay, Year)

AUG 26

32. Registrer's Signeture

Registrar

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1998

10g. Citizen of Whet Country? U.S.A. 14. Raca - American Indien,

Department Store

White

3. Time of Deeth

9. Birthplece (Stete or Foreign Washington DC

10d. Inside City Limits 1 ☐ Yes 2 ☐

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August

18

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			VAMC FORT HOWA 5. Social Security Number 6. S			ast birthday)	If Under 1						
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	deeth with the Merylend ms 23a or 28a-f show	al Director	10e. Street end Number 2002-D Wedgewoo	d Place			10f. Zip C 206				10g. Citizen of U	Whet Co	
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St.	72 ho	eted	15. Decedent's Ed (Specify only highest gre	ducation		16e. Decede	ent's Usuel (Occupation done during mos	t of work	ina	16b. Kind of B	usiness	i/Industry
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AKA			20e. Method of Disposition 1 Burial 20 Cremetion 3 5 4 Donetion 5 Other (Specific	Removel from State	CE	eca of Dispos	ition (Neme etory or othe	of	1	Dete	20c. Location	Clty or	r Town, Sta
Balti	permit. Page Department of Important: If any Injury or otice.		21 Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Fune 6633 Old Alexandria Fer										
٦	Physician /Medical Examiner		Immediete Cause (Figur diseese or condition resulting in death)	. Non Sma		Cell (noma O	f L	ung			Мог
P.O. Box 68760.	Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours efter deeth. Funeral Director: After this certificate hes been signed by the ettending physician and sely filled in by the funeral director, page 2 should be detached for use as the buriel-trensit		Sequentially list conditions, if eny, leeding to immediate cause. Enter Undertyling Cause (Disease or Injury that initiated events resulting in death) Lest	c		es e consequ							
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sion	ending P seth. or: After t	r: After this is to funeral direction: To	27. Menner of Deeth 1 ⊠Netural 5 ☐ Pending 2 ☐ Accident Investigation		Year)	28b. Time of Injury	M 28c	Injury et Work? 1 Pes 2	No	28d. Describe	how injury occur	red	
Divis	To the Hospital or Attending Physician: The law within 24 hours efter deeth. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2	Certification:	3 Suicide 6 Could not be determined	building, etc	. (Specity,)				City or To			
	To the Hospital within 24 hours e To the Funeral C completely filled	edicai	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best o niner: On the bests of end menner sta	examineti	viedge, death ion end/or inve	occurred et estigation, In	he time, date en my opinion, dea	d placa, th occur	end due to the red et the time,	ceuse(s) end mo date end plece,	end du	s steted. e to the ca
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1. Decedent's Neme (First, Middle, Last)

4e Fecility Neme (If not institution, give street and number)

William

Stone

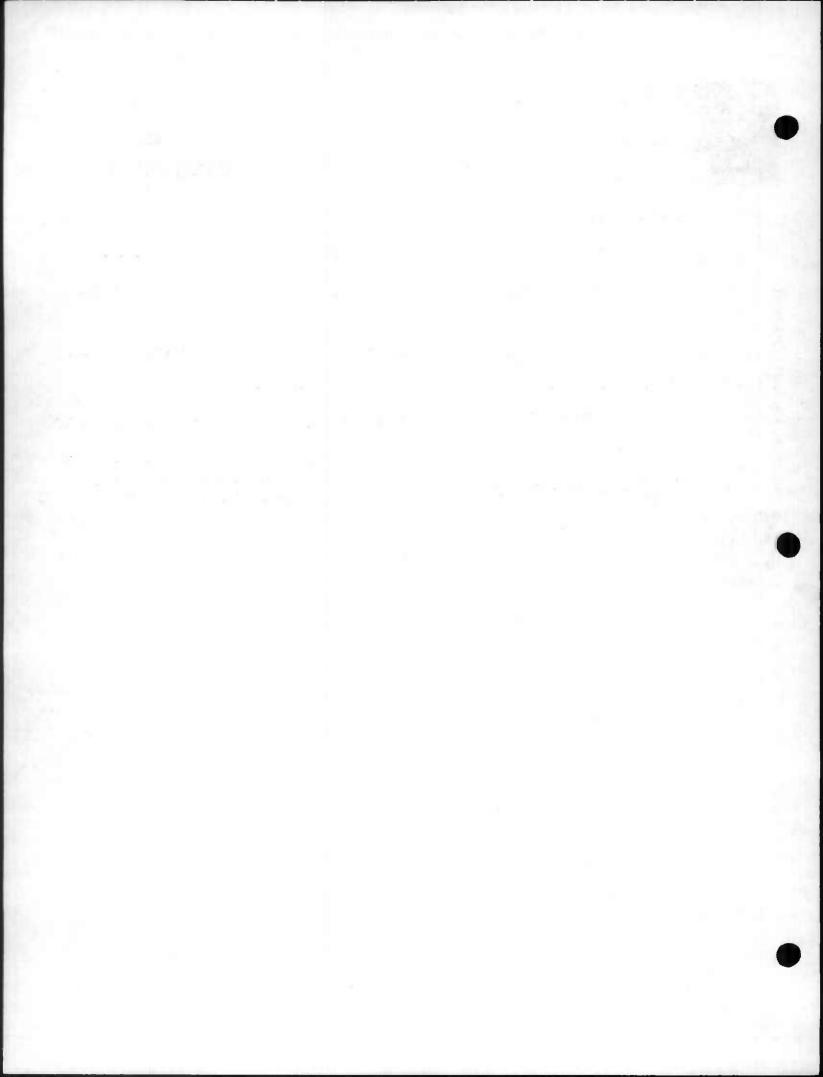
Thomas

Physician

/Medical

Waldorf, Maryland 20602 20c. Location - City or Town, State 998 Clinton, Maryland Funeral Home, Inc. Ferry Rd Clinton, MD 20735 spiretory errest, Approximete Intervel Between Onset end Deeth Months 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings evelleble prior to completion of cause of deeth? 24a. Was en eutopsy performed? N/A 1 ☐ Yes 2 1 No 1 ☐ Yes 2 ☐ No eck only one) 5 ☐ Residence 6 ☐ Other (Specify) Describe how Injury occurred 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred et the time, date end placa, end due to the ceuse(s) end menner es steted. 2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, death occurred et the time, date end plece, end due to the cause(s) end menner stated. 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) 156 28 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Caroline Custodio, MD 9600 North Point Road Fort HOward, MD 21052 31. Dete filed (Month, Dey, Year) 32. Registrar's Signeture

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended # 11. Per F.H. PGC 8-20-98 cr Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Bria Scott AUGUST 15 1998 Linnette 1:15 am /Medical 4b. City. Town, or Location of Death 4e Facility Neme (If not institution, give street end number) 4c. County of Death Examiner THE JOHNS HOPKINS HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 MARYLAND 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Dey, Year) Days 15 Hours 1 M 2 TYF Vrs 212-53-4988 MAY 31, 1998 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1. Yes 2 □ No Director MARYLAND BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21225 4135 DORIS AVENUE Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Merital Stetus 1 Yes 2 No
If Yes, Give
Yeer or Detes: 1 Never Merried 2 Married 1 ☐ Yes 2 ☼ No Specify: Specify: BLACK p 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) NONE NONE 0 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) Be TINA CARTER EARL SCOTT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) TINA CARTER 4135 DORIS AVENUE, BALTIMORE, MD 21225 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) AUG. 18, ZION BAPTIST CHURCH CEM. LOTTSBURG, VA 1998 BERRY O. WADDY POBOX 305 21, Signature of Funeral Service Licensee 22. Name end Address of Fecility 6784 MARY BALL ROAD LANCASTER, VA 22503 23a. Part I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Examiner Bowe NCC1051 Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) enterocolitis Nocro hzing Physician/Medicai Due to (or es e consequence of) Omchi. Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown by 24b. Were eutopsy findings eveilable prior to completion of cause ot death? 24a. Wes en eutopsy Completed performed' 1 Tyes 2 No 1 ☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred Certification:

/Medical Examiner physician and the bunal-transit The lew requires that the death certificate be executed Box 68760, deteched Division of Vital Records, P.O. signed by t d be detech should page 2 certificate Physician: director, this : After t or Attanding death. Director: 24 hours e Hospital within 2 0

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

the Maryland

death

72 hours efter

filed within Hygiene.

permit. Pages 1 and 2 should be file Department of Health end Mentel Hy Important: If Item 27 is marked other any injury or other traumatic avent, page.

Physician

Baltimore, Maryland 21215-0020

28a. Date of Injury (Month, Dey Yeer) 28c. Injury at Work? 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 29e. Certifier t<mark>⊠ Certifying Physician:</mark> To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the ceuse(s) and menner as stated 2 Medical Examinar: On the basis of exemination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29c, License number

ES-000

edicai

Jettrey Keefe-31. Date filed (Month Day, Year)

AUG 2 0 1998

29b. Signature and title of certified

MD 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Johns Hopkins Hospital Department of pediatrics.

29d. Date signed (Month, Dev. Year)

August 15

DHMH 16 Rav 6/95

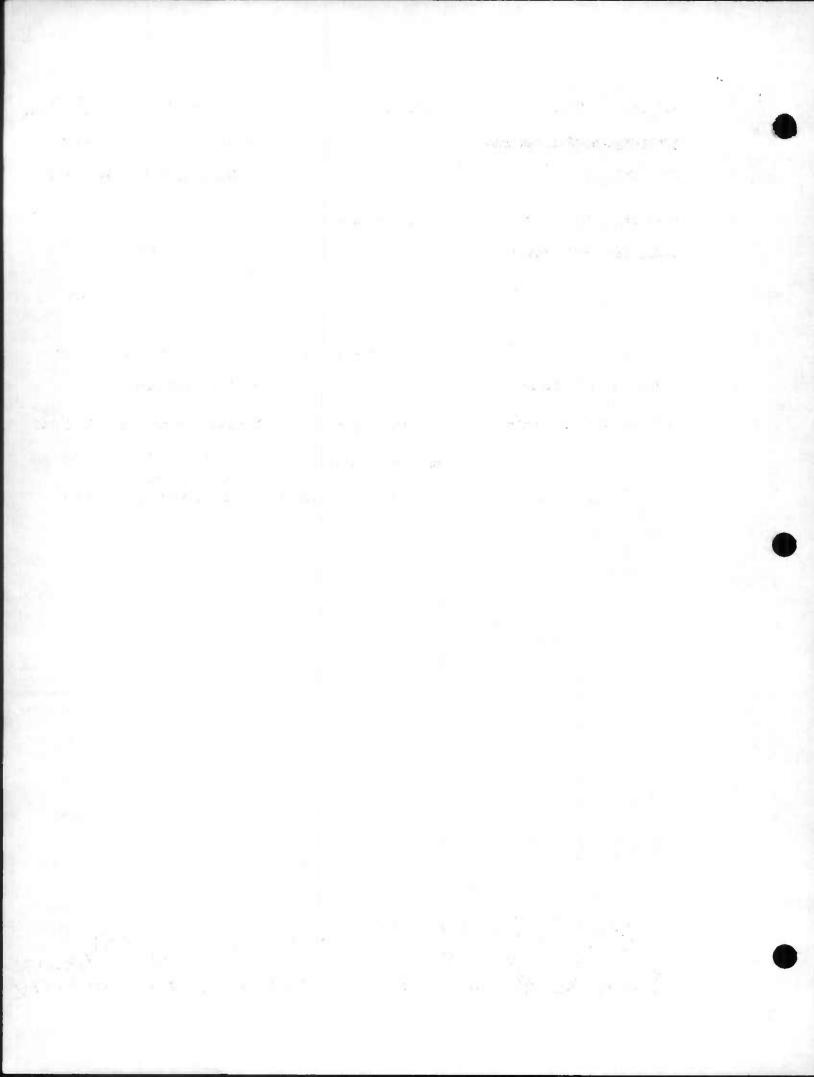
Registrar

from the first

SE SESSION

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	.*		Certificate of Death Reg. No.	
П	Physici	an	1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Dey Year 2.3	
	/Medic	al	William Cleo TASKER August 25, 1998 327 pt	1
	Examir	er	4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth 4d. County of Deeth Washington	
	Funeral			าก
	Director		5. Social Security Number 20-30-8231 Outside Security Number 4. Sex Notes (In yrs. lest birthdey) 4. Sex Notes (In yrs. lest birthdey) 4. Sex Notes (In yrs. lest birthdey) 4. Sept. 12 1933 Outside Security Number 4. Sex Notes (In yrs. lest birthdey) 4. Sept. 12 1933 Outside Security Number 4. Sex Notes (In yrs. lest birthdey) 4. Sept. 12 1933 Outside Security Number 5. Sept. 12 1933 Outside Security Number 6. Sex. 12 1933 Outside Security Number 6. Sex. 12 1933 Outside Security Number 7. Sept. 12 1933 Outside Security Number 7. Sept. 12 1933 Outside Security Number 7. Sept. 12 1933 Outside Security Nu	
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	or 284	irec	10e. Streel end Number 10f. Zlp Code 10g. Citizen of Whet Country?	
	23a	rai	1749 Edgewood Hill Circle 21742 USA	
020	72 hours after death with the Man/end natural; or Items 23a or 28a-f show dieal Examiner must be notified at	by Funeral Director	11. Meritei Status 1	
21215-0020	within sne.	Completed	15. Decadent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) Coilege (1-4or 5+) 12 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 1 nstaller 16b. Kind of Business/Industry telephone company	
	Hyg the		12 0 installer telephone company 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme)	
lan	of a b	To Be	James Edward Tasker Ada Ruth Johnson	
Maryland	SPEE		19e. informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)	
	ロミトコ		Jean E. Tasker - wife 1749 Edgewood Hill Circle, Hagerstown, Md. 21742	
Baltimore,	Peges nent of int: If It ary or o		20a. Method of Disposition 1	
Balt	permit. Peg Depertment Important: I any Injury o		21. Signeture of Funerel Service Licensee 22. Name end Address of Fecility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740	
H			23e. Pert1. Enter the disease, or complications that caused lhe deeth. Do not enter the mode of dying, such as cerdiec or respiratory errest, shock, or heart leiture. List only one cause on each line. Approximate interval Between	
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68760,	ate by hysici the bu	edical	Inter interest events Due to (or es e consequence of);	
Box 6	the deeth certific y the attending p sched for use as	Physician/Me	METASTASE TO CUNO, SKULL AND BRAIN MINT	K
	he att	sici	Pert ii. Other significant conditions contributing to death but not resultine to the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death	1?
, P.O	thet ed b dete	by Phy	(HAUNIC OBSTRUCTIVE PRINCE PODENTY 1 NO 3 Probably 4 Unknown	พก
of Vital Records,	ew requii 1s been s 2 should	Completed t	24a. Wes en eutopsy performed? 24b. Were eutopsy findings evellable prior to completion of cause of death?	
<u>=</u>	E ag	Con	1 ☐ Yes 2 ☐ NO 1 ☐ Yes 2 ☐ No	
Vita	Physician: The	Be	25. Wes case referred to medicei examiner? Hospital: Other: Other:	
on of	2 00	tlon: To	To perital: 1 inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Accidence 6 Other (Specify) 27. Menner of Deeth 1 Naturei 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury M 28c. injury et Work? 1 Yes 2 No 28d. Describe how injury occurred 28d. Describe how injury occurred	
Division	To the Hospital or Attending Ph within 24 hours after deeth. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined Could not be determined Could not be determined 28e. Plece of Injury - At home, larm, street, lectory, office 28l. Location (Street and Number or Rural Route Number, City or Town, Stete)	
	thin 24 hours in the Funeral in mpletely filled	edicai (29e. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and manner es stated. 2 Medical Examiner: On the best of examination and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and manner stated.	
	To the within To the comple	W	29th. Signature of the describer For Awa () 17(0, the) 29th. License number 29th. Detection of Month, Day, Year)	
			30. Name and address of person who completed ceuse of deeth (item 23a) (Type, Print)	rec
		10	31. Dete flied (Month, Dey, Year) 32. Registrer's Signeture	2
	Sta Registr		AUG 2. 8. 1998 Server 4. April 1	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decadant's Nama (First, Middla, Last) 2. Data of Daath Month **Physician** DELLA ALICE TALBERT August 19, 1998 3:15 AM /Medical 4a. Facility Nema (If not institution, give streat and number) 4b. City, Town, or Location of Deeth **Examiner** 4c. County of Daath Ravenwood Lutheran Village Hagerstown Washington Hunder 24 Hrs. 8. Data of Birth Hours Min. June 13, 1899 5. Social Security Number If Under 1 Year 6. Sax 7. Aga (In yrs. last birthday) Birthplaca (State or Foraign Country) **Funerai** Days 1 M X F 99 214-09-4856 Yrs. Maryland Director Usual Rasidance of Decedant the Marylend 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show the Medical Examiner must be notified at Washington Hagerstown Director 1 Yas 2 No 10e. Street end Number 10f. Zip Coda 10g. Citizen of What Country? , or items 23a or 1183 Luther Drive 21740 U.S.A. death Funeral 12. Was Decedant Evar in U,S. Armad Forces? 1 ☐ Yas 2 ☐ No Was Decedant of Hispenic Origin? (Spacify Yes or No. If Yes, specify Cuban, Maxican, Puarto Rican, atc.) Race - American Indien, Black, White, atc. filed within 72 hours efter 1 Never Married 2 Married Baltimore, Maryland 21215-0020 If Yes, Giva Yaar or Datas: 1 ☐ Yas 2 XNo Spacify: Specify: White þ 3 Widowed 4 □ Divorced "natural", Completed 16a. Decedant's Usuel Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 15. Decadant's Education 16b. Kind of Businass/Industry (Specify only highast grada complated) Hygiene. Elamantary/Secondary (0-12) Collaga (1-4or 5+) permit. Pages 1 and 2 should be filled wit Department of Health and Mental Hygiene Important: If Nem 27 is marked other that any linury or other traumatic event, and once. Manager Dry Cleaners 17. Father's Nama (First, Middla, Last) 18. Mothar's Name (First, Middla, Maiden Sumama) Be Thomas Jefferson McLucas Mary Alice Virginia Shoemaker 2 19e. Informant's Name/Ralationship (Typa, Print) 19b. Mailing Addrass (Straat and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) Teressa L. Preston 10806 Rosewood Drive, Hagerstown, Maryland 21740 20b. Place of Disposition (Nama of 20a. Mathod of Disposition 20c. Location - City or Town, Stata N Buriel 2 ☐ Cramation 3 ☐ Ramovai from Stata Stone Bridge Church Cem. 08-21-98 Millstone, Maryland 4 Donation 5 Other (Spacify) 21. Signature of Funaral Service Licansaa ²² Andrew K. Collman Funeral Home, Inc. hoel to 40 East Antietam Street, Hagerstown, 23a. Part1. Enter the disaasa, or complications that caused the deeth. Do not antar the mode of dying, such as cardiec or raspiratory errest, shock, or haart failura. List only ona causa on aach lina. Approximata intarvai Batween Onsat and Death **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in daath) a Cardiopulmonary arrest due to instant Examiner Due to (or as a consequance of): many Examiner b. Chronic congestive heart failure years The law requires that the death certificate be executed ettending physician end for use es the buriel-trensit Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Disaasa or injury that initiated avants rasulting in deeth) Last Dua to (or as a consequence of): many Records, P.O. Box 68760. c. Coronary Artery Disease Physician/Medicai years Due to (or es a consequence of): for use es detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 3 Probably 4 Unknown 1 Yes 2 No Chronic Renal Insufficiency, Hypertension þ director, page 2 should be 24b. Wara autopsy findings aveileble prior to completion of causa of daath? Completed 24a. Wes an autopsy performed? After this certificete 1 Yas 1 ☐ Yas 2 ☐ No of Vital or Attending Physician: Be 25. Was casa refarred to medical 26. Placa of Daath (Check only ona) 1 Yas al No Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) Certification: To 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA filled in by the funeral 27. Manney of Daath 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how Injury occurred Division 1 Naturai 5 Panding Invastigation s efter death. 1 Yas 2 No 2 Accident 3 Suicida 6 Could not be detarmined 28a. Piace of Injury - At homa, farm, straet, factory, office building, atc. (Spacify) 28f. Location (Straet end Number or Rural Route Number, City or Town, Stata) 4 Homicida To the Hospital o within 24 hours of To the Funeral Di completely filled in 1 Certifying Physician: To tha best of my knowledga, daath occurred et tha tima, date and plece, end due to tha causa(s) and menner as statad.
2 Medical Examinar: On tha bests of axemination and/or investigation, in my opinion, deeth occurred at tha tima, data and place, and dua to tha cause(s) and mannar stated. 29a, Certiflar Medicai (Check only one) 29b. Signatura and title of certifian 29c. Licensa number 29d. Date signed (Month, Day, Year) D07857 August 20, 1998 30. Nama and address of person who completed causa of deeth (Item 23a) (Type, Print)

DHMH 16 Ray 6/95

State

Registrar

Edson Moody M.D.,

AUG 2 4 1998

31. Date filed (Month, Day, Year)

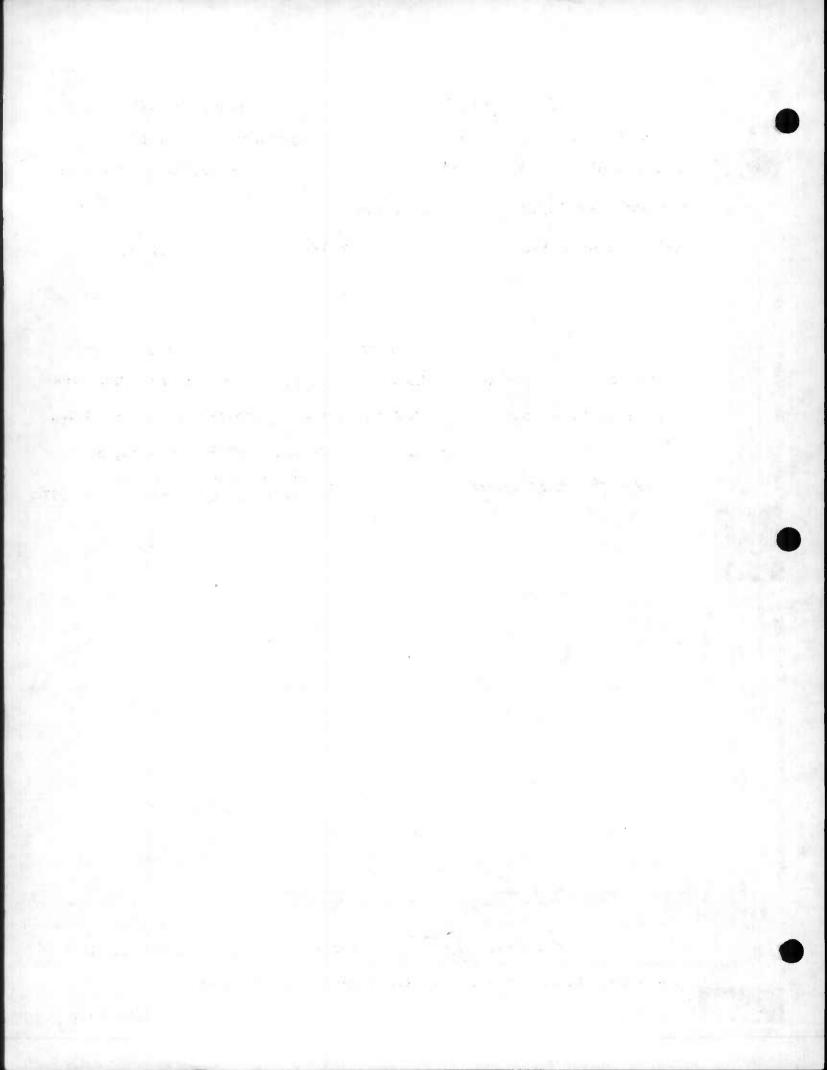
1190 MT. Aetna RD,

12. Registrar's Signeture

Hagerstown, MD

21740

Della Alice TALBERT



State of Maryland / Department of Health and Mental Hygiene

		The state of the s	Certificate of	Death	Re	g. No.	21255
Dhualalan	1. Decedent's Name (First, Middle, Last,				2. Date of Deetl Month	h	3. Time of Deeth
Physician /Medical	HELENA	MAE THORNE				6, 1998	
Examiner	4a Facility Name (If not institution, give 2566 MINDI DRIVE	street and number)		4b. City, Town, or MANCHES		4c. County of CARR	
Funeral Director	5. Sociel Security Number 6. Set 577–12–0787	7. Age (In yrs. les	st birthdey) If Under 1 Yea Months Dey		8. Date of Birth (Month, Dey, NOV 1,	Year) 1913 W	Birthplace (State or Foreig Country) ASHINGTON DC
e Meryland a-f show uted at	10a. State 10b. County MARYLAND CARRO		Town or Location	MANCHEST	'ER		10d. Inside City Limit
offer death with the Me	10e. Street end Number 2566 MINDI DRIVE		10f. Zip Code	21102		og. Citizen of Whe	t Country?
0 0	1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2½ No If Yes, Give Year or Dates:	13. Was Decedent of If Yes, specify Cu	ban, Mexicen, Puert	pecify Yes or No- o Rican, etc.)		Americen Indien, White, etc. WHITE
natural natural	15. Decedent's Edu (Specify only highest gred		16e. Decedent's Usual Occ (Give kind of work don life. DO NOT use retii	upation e during most of wor	tking	16b. Kind of Busin	ess/Industry
	Elementery/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retir HOUSEWIE			OWN	HOME
be file d oth svent	17. Father's Name (First, Middle, Lest)				ne (First, Middle, M	faiden Sumame)	
s should be end Mentet s marked o numetic sve					LEWIS		. 7. 6
1 end 2 should be file Heelft end Mentet hy am 27 is marked oth other traumetic svent To Be (19a. Informant's Name/Reletionship (Ty JACQUELYN SZYMANS:		19b. Meiling Address (Street 2566 MINI				
Peges nent of ant: if it ary or o	20a. Method of Disposition 1 🖫 Burial 2 🗆 Cremetion 3 🗆 R 4 🗆 Donation 5 🗀 Other (Specify)	Removel from State cen	ce of Disposition (Neme of netery, crematory or other p		Date 2	20c. Location - Cit	
permit. Peg Depertment Important: i any injury o	21. Signature of Funeral Service Licens	2 Eline	22. Name end Add	ress of Fecility E	LINE FUN		
Physician /Medical Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in deeth)	Rad	Luc camor es a consequence of):	ying, such as cerdia	c or respiratory erre	981,	Approximete Interval Between Onset and Deeth
certificate be executed nding physicien end use as the buriel-transit nr/Medical Examiner	Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last	Due to (or e	es e consequence of):				
death ce ettendi	Pert II. Other eignificant conditions con	ntributing to death but not result	ing in the underlying cause	given In Pert I.	23b. Did to	bacco use contri	bute to the cause of deat
that the ed by th detech	Conquestion	· Hent fait			1 🗆 Ye	s 2 NO 3	□ Probably 4 □ Unkno
The law requires that sele has been signed by pege 2 should be determined.	U				24a. Wes en		24b. Were eutopsy finding: avallable prior to completion of ceuse of deeth?
F 56 0	Control of the Control				1 □ Y€	s 2DHO	1 ☐ Yes 2 ☐ No
yslcian: The is certificate director, peg	25. Was case referred to medical examiner?	No No. 1			ath (Check only on	Θ)	
S S D	1 Yes 212 TNO	1 Inpatient 2 E	AVOULDBUILDING 30 DOA		lome 6 Reside		(Specify)
After funer	27. Manner of Death 1. Natural 5 Pending	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury M 28c. In	lork? ☐ Yes 2 ☐ No	28d. Describe no	ow injury occurred	
To the Hospital or Attanding Phwithin 24 hours effer deeth. To the Funeral Director: After this completely filled in by the funeral Medical Certification: 7	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Plece of Injury - At hom building, etc. (Specify)			28f. Location (St City or Town		or Rural Route Number,
ne Hospiu n 24 hours he Funera pletely fille edical (29a. Certifier 1 Certifying Physical Check only one) 2 Madical Examination	elclan: To the best of my knowledge. On the basis of examination and manner stated.	ledge, death occurred at the on and/or investigation, in my	time, date and plece opinion, deeth occu	e, and due to the coursed at the time, do	euse(s) and menn ate and place, end	er es steted. I due to the ceuse(s)
within To the comp	29b. Signature and Rie of certifier			nse number	2	9d. Date signed (i	Month, Day, Year)
	1/2	MA		33165		81.1	94
	30. Neme and eddress of person who co	C (1	23a) (Type, Print) M. Lamas Pile	Hampsh	ws su	14	
State	31. Dete filed (Month, Day, Yeer)	32. Registrar's Signetu		·V			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 2. Data of Death Day Physician 20, HAZEL IRENE WARNER 1998 9:50 PM. AUG. /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner WESTMINSTER 82 E. NICODEMUS RD. CARROLL If Undar 1 Yaar | If Undar 24 Hrs. | 8. Data of Birth (Month, Day, Year) 5. Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** Months Days 1 □ M 2 0 F Yrs. 216-22-9214 73 Director 6/28/1925 MARYLAND Usual Rasidance of Decedant the Marylend 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yas 2 No CARROLL WESTMINSTER MD. Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 82 E. NICODEMUS RD. 21157 USA deeth Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas ♣DNo If Yes, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, 11. Marital Status Black, Whita, atc. Pages 1 and 2 should be filed within 72 hours efter onent of Health and Mentel Hygiene. Int: If Itam 27 is marked other than "natural", or Iter 1 ☐ Navar Marriad 2 ☑ Married 1 Yas 2 No Specify: Specify: WHITE by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedant's Usual Occupation
(Giva kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada completed) Collega (1-4or 5+) Elementery/Secondary (0-12) HOUSEWIFE HOME MAKING 18. Mothar's Nama (First, Middla, Maiden Sumama) 17. Father's Nama (First, Middle, Last) marked NORMAN JACOB HAPE HILDA IRENE GRIMES 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 2.1.1.5.7 19a. Informant's Name/Ralationship (Typa, Print) ALFRED O. WARNER, SR.-HUSBAND 82 E. NICODEMUS RD., WESTMINSTER, MD. itam 2 20b. Placa of Disposition (Nama of cematary, crametory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1X Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata = 0 permit. Pege Department of important: if any injury or once. EVERGREEN MEM.GARDENS8/24/98 FINKSBURG, MD. 4 ☐ Donation 5 ☐ Othar (Spacify) 22. Name and Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157 23a. Part1. Entar tha disaasa, or com shock, or haart failura. List only ations that causad tha daath. Do not antar tha mode of dying, such as cardiac or respiratory arrest, Approximata Intarval Batween Onsat and Death **Physician** Respirating /Medical Immadiata Cause (Final disaasa or condition rasulting In death) Examiner Due to (or as a consequence of) Physician/Medical Examine Adem concerna physicien end the burial-transit The law requires that the death certificate be executed Sequantially list conditions, if eny, leading to immadiate causa. Enter Undarfying Cause (Disaasa or injury that initiated avants rasulting in daath) Last Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Dua to (or as a consaquanca of): 98 use Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Unknown by 24b. Wara autopsy findings available prior to complation of causa of daath? 24a. Was an autopsy Completed certificate has blirector, page 2 s 1 ☐ Yas 2 No 1 ☐ Yas 2 ☐ No Physician: 25. Wes casa rafarrad to madical axaminar? 26. Place of Death (Check only one) Be Hospitel: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yas 2 No Othar: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 2 this 28a. Data of Injury (Month, Day Year) 28d. Dascribe how Injury occurred 27. Mannar of Death 28b. Tima of 28c. Injury at Work? Certification: Aftert or Attending 1 Naturel 5 Pending 1 ☐ Yas 2 ☐ No deeth. ector: Invastigation 2 Accidant 6 Could not be detarmined 3 ☐ Suicida 28a. Place of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) To the Hospital or Atte within 24 hours effer de To the Funeral Directo completely filled in by the Location (Street and Number or Rural Routa Number, City or Town, Stete) 4 T Homicida 1 Certifying Physicien: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and mennar es stated.

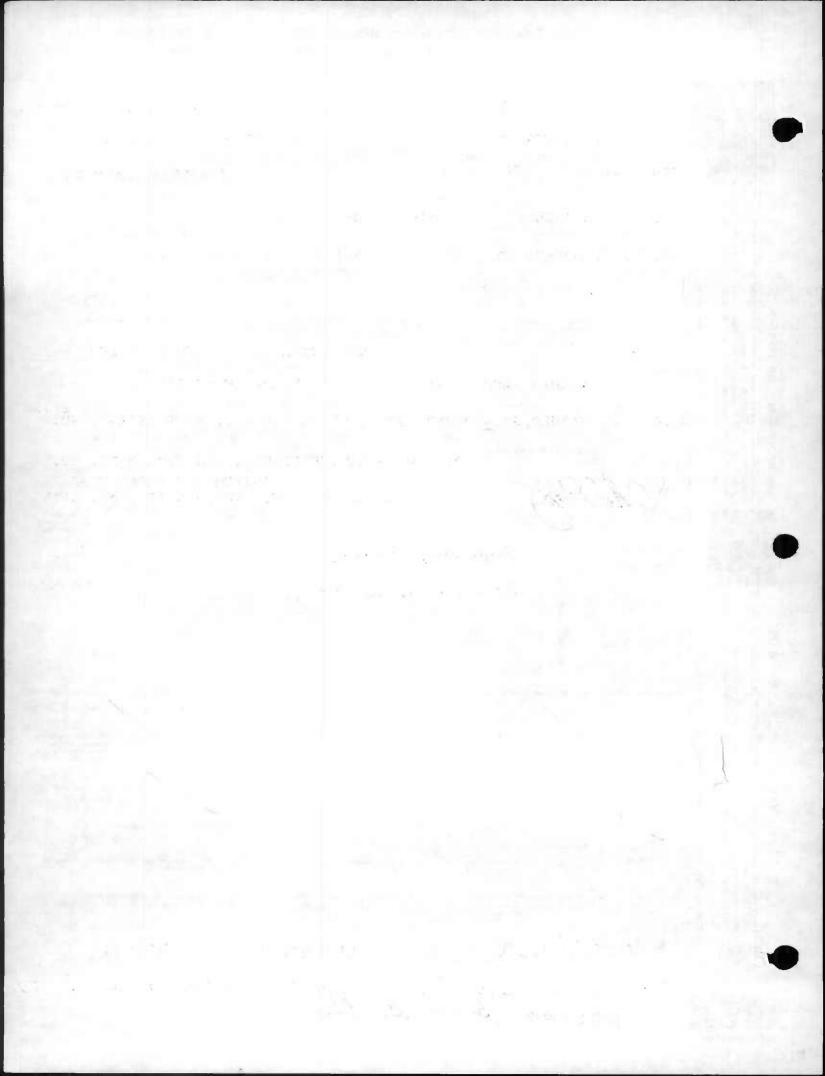
2 Medical Exeminar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29a. Cartifiar (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifian 29c. Licansa number

912 Washing an RQ. Westminster MD. 21157.

Registrar

30. Nema and eddrass of person who completed cause of daath (Item 23e) (Type, Print)

AUG 2 4 1998



Piease Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dale of Death 3. Time of Death Month Da Day **Physician** EDITH C. ANTHONY /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner UNIVERSITY OF MARYLAND MEDIUM SYSTEM BACTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State **Funeral** 1 M 2 F Hours 21354 2966 Director Usual Residence of Decedent the Maryland 10b. County 10a State 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No BALTIMORE Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with to not of Health and Mental Hygiene.

nt: If tem 27 is marked other than "natural", or itema 23a or? 7 is marked other than "natural", or itema 23a or traumatic event, the Modical Examinal must be AVE. ZND FL Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 IV No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 🗙 No Baltimore, Maryland 21215-0020 Specify: Specify: BLACK py 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 10.33119 Guard 17. Fether's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Sumame) Be phen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9) 132-1 Myr+ Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location Important: If it any injury or o Burial 2 Cremetion 3 Removel from State **Jepartment** 4 ☐ Donation 5 ☐ Other (Specify) HON CEN 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Winner Fig. . Enfer the disease complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure cont only one cause on each line. **Physician** /Medical Immediate Cause (Final MULTI-SYSTEM ORGAN FAILURE MAVONA disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner UNKNOWN Sequentially list conditions, if any, leading to immediate cause. Enler Underlying Ceuse (Disease or Injury that initieted events resulting in death) Last Due to (or as a consequence of): physician and the burial PERINEPHPIC ABSCESS UNKNOWN Division of Vital Records, P.O. Box 68760 Physician/Medicai 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 2DUNO 3 Probably 4 Unknown 1 Yes CIRMONS þ 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? Completed 200No 1 Tyes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Impatient 2 ☐ ER/Outpatien1 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 1 W Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury el Work? Attending 5 Pending 1 Yes 2 No 2 Accident Investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide b 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29b. Signature and this of pertition 29c. License number 29d. Date signed (Month, Day, Year)

51.

22 S. CREAGE

32. Registrar's Signature

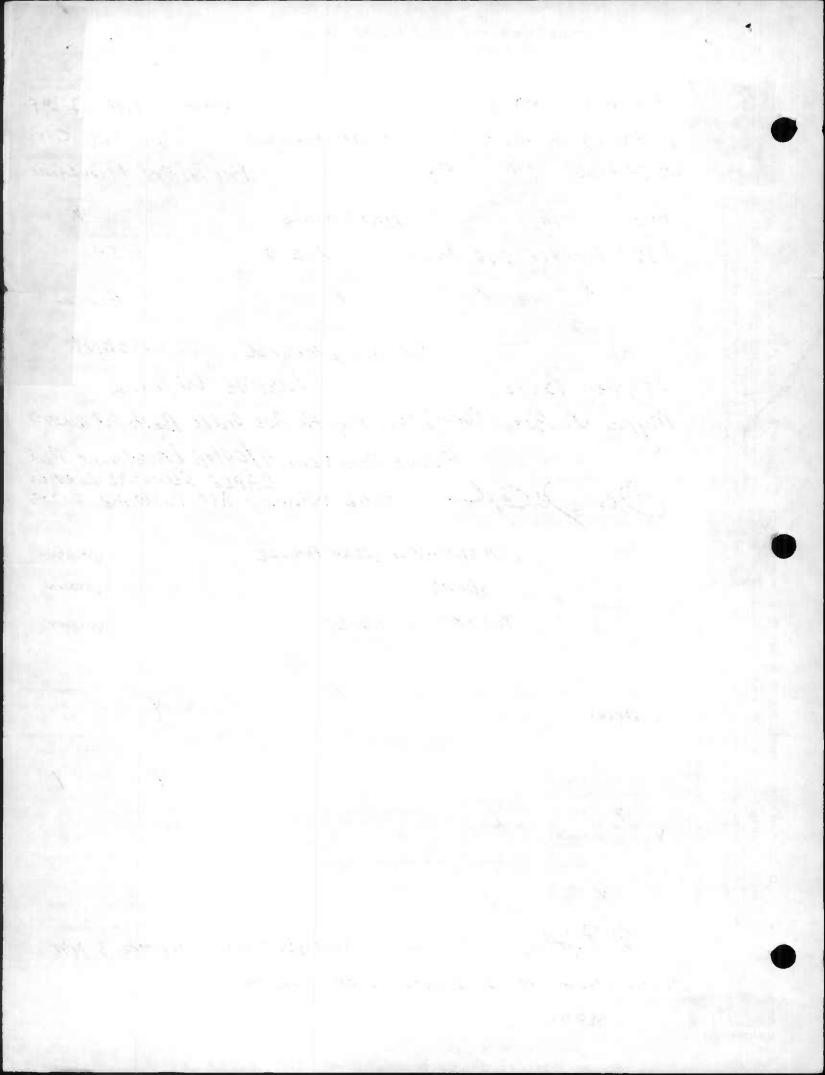
State Registrar MICHAGE

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

EBRIGHT, MO

SEP 0 8 1998



State

Registrar

31. Dete filed (Month, Dey, Yeer) \$20 0 8 1998

30. Name and address of person who completed cause of death (Item 230) (Type, Print)
CHARU MEHTA, MD. 8775 Cloudleap Ct, #224, Columbia, M D21045 32 Registrer's Signature

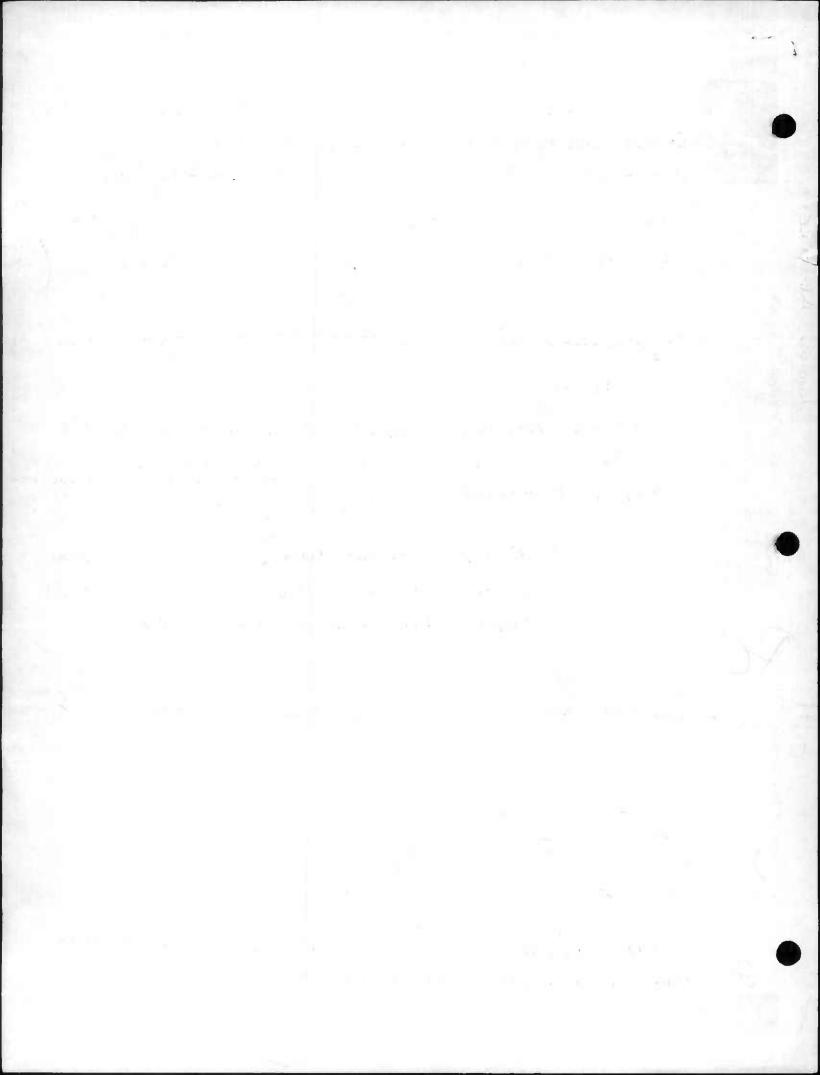
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Maryland 21215-0020

Division of Vital Records, P.O. Box 667

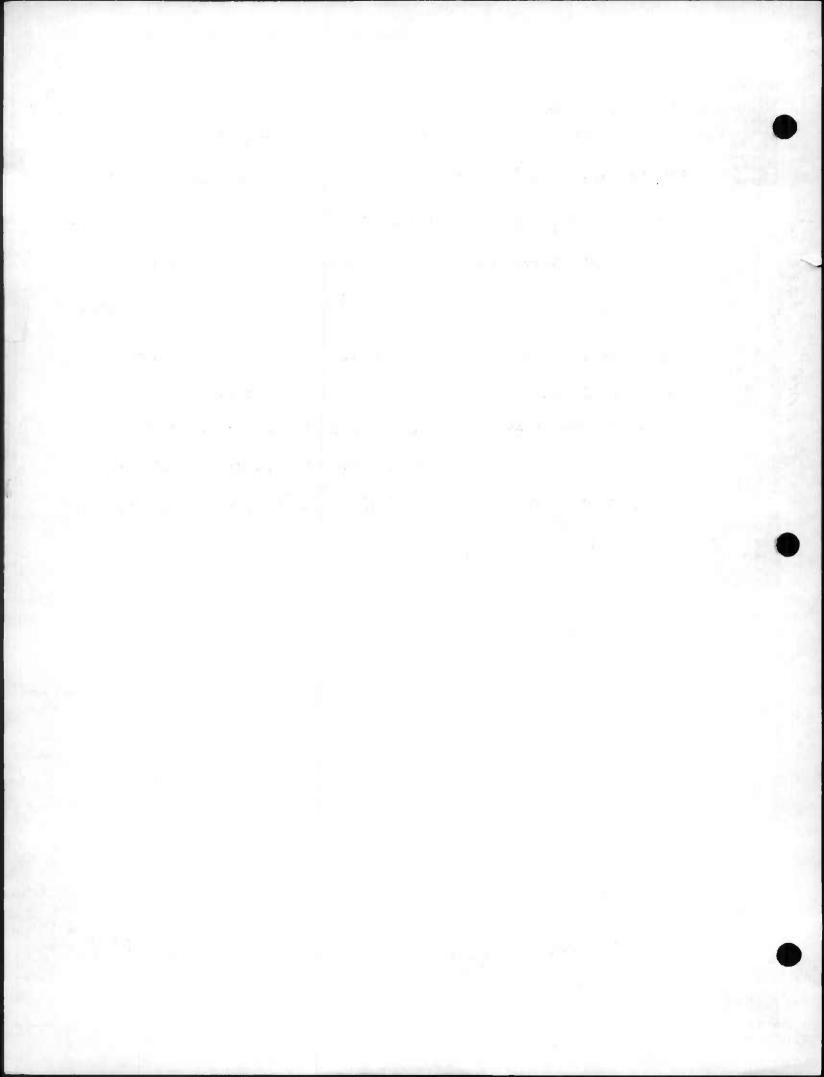
or Attending Physician: The law requires that the



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

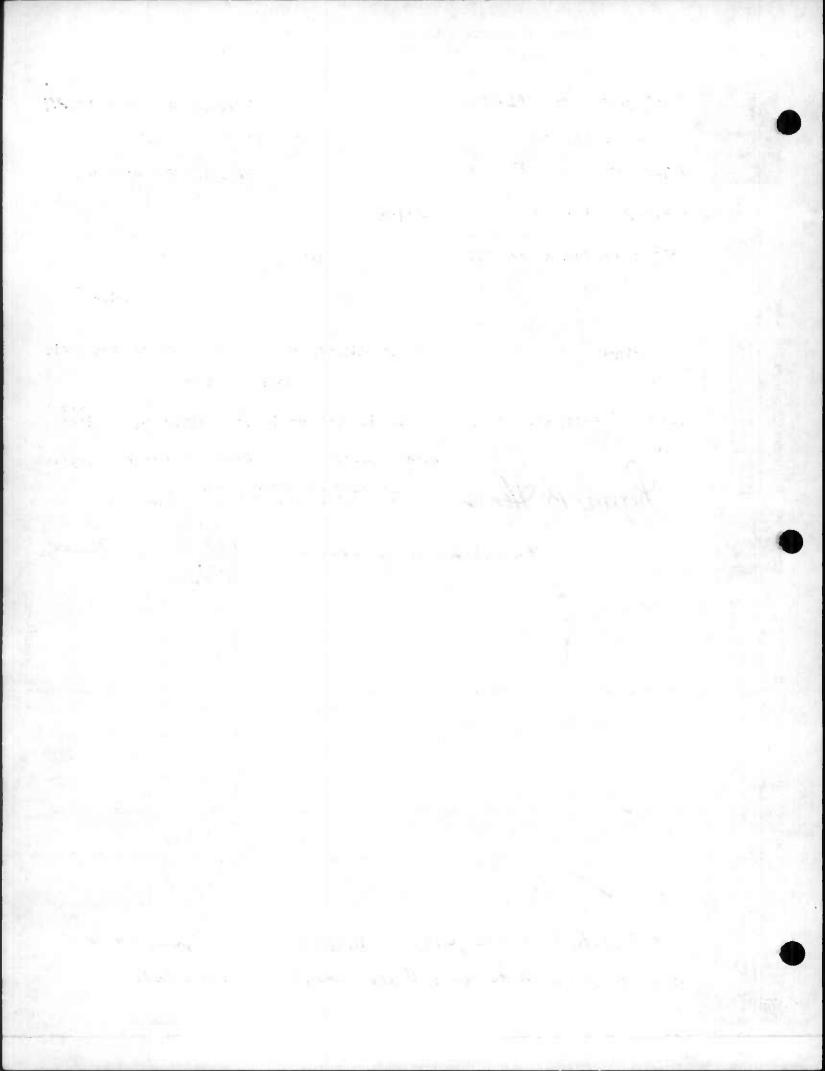
		Decedent's Neme (First, Middle	(ant)		Certifi	cate of	Death		Reg. No.	((J J
Physic	ian							2. Dete of De	Day	Y9950 1	Time of Deeth
/Medi		HARRIET ALST 4a. Fecility Neme (If not institution		hari			4b. City, Town, or	Location of Doeth	Dek 2/	948 a	30/1/11
Exami	ner	Manauland C	0000.1	1/penit	20		Bollem	PA Profu	4c. County	of Deeth	
		5. Social Security Number	6. Sex 7	Age (In yrs. last i	hirthday) If I	Under 1 Year	If Under 24 Hrs	a Date of Bir	h	O Bisheless	(Chata as Familia
Funeral Director		215-60-3919 Usuel Residence of Decedent	10 M 20 F	46		onths Deys	Hours Min			Country) MD	(Stete or Foreign
B # 11		10e. Stete 10b. County		10c. City, To	wn or Location	n				10d. lr	nside City Limits
death with the Maryand free 23s or 28s-f show Emust be notified at	ō	MD NA		Bal	Ltimor	e				X	Yes 2 No
# 85	Funeral Director	10e. Street end Number				Of. Zip Code			10g. Citizen of V	Whet Country?	
23s or	0	607 Coores S	though An	+ 2		21201			U.S.A		
ler death flerns 2 iner.mu	Jer	607 George S	12. Was Deced	lent Ever in U,S.	13. Wes I		lispenic Origin? (S en, Mexicen, Puer	Specify Yes or No	14. Rad	e - Americen In	dlen,
	by Fui	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☑ Divorced	Armed Force 1 Yes 2 If Yes, Give Year or Det	2 X No		s, specify Cubi res 2X No		to Rican, etc.)	Specify	ck, White, etc. Black	
	8				a. Decedent's	S Usual Occup	ation		16b. Kind of B	usiness/Industry	
21215-C	Completed	15. Decedent (Specify only highes Elementery/Secondery (0-12)	t grade completed) College (1-4	Ant Eu	(Give kind life. DO N	of work done IOT use retired	during most of wo	rking			
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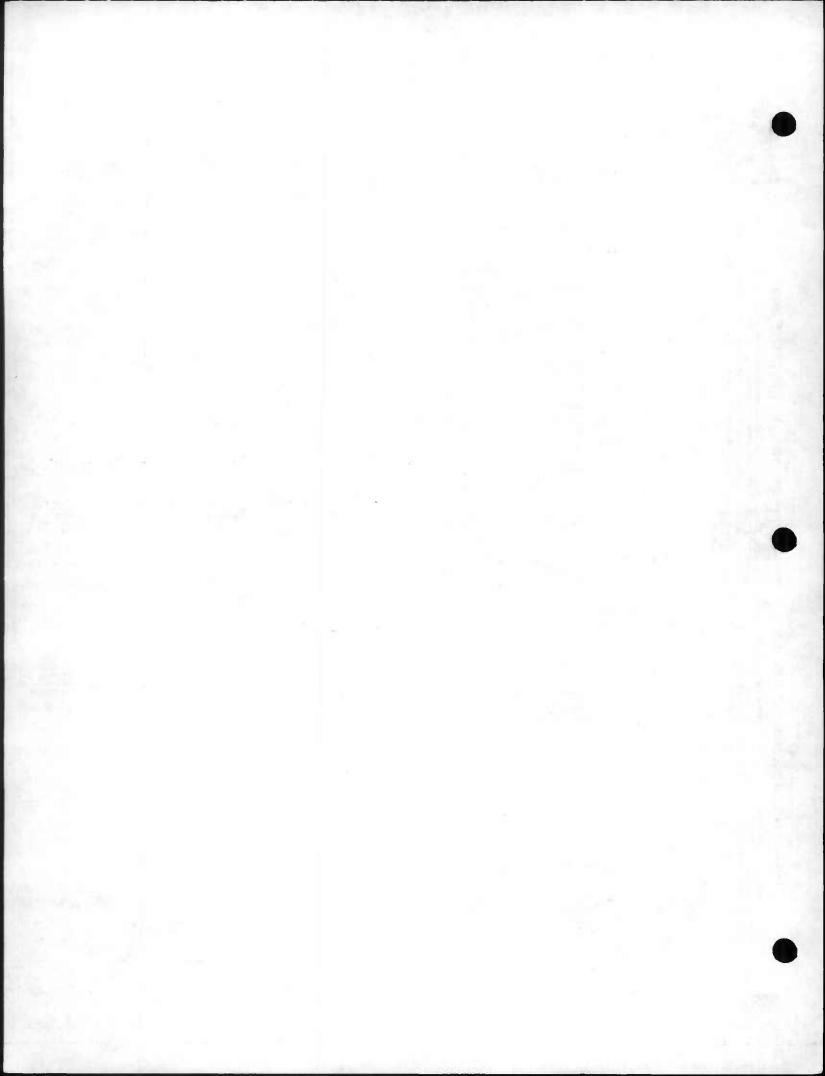
State of Maryland / Department of Health and Mental Hygiene

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how		Usual Residence of Decedent 10e. Stete 10b. County	1	0c. City, Town or					10d. Inside City Lir
Sa-f s	Director	Maryland N/A		Balt	imore				XIXYes 2□
23a or 2	rai Dire	3838 Roland Avenue	e Apt 1409		10f. Zip Co	21211		10g. Citizen of What	Country?
natural', or Items 23a or 28a-f show	by Funeral	11. Merital Stetus 1 Naver Merried 2 Namied 3 Widowed 4 Divorced	12. Was Decedent Eva Armed Forces? 1 ☐ Yas 2 ☐ No if Yes, Give Yeer or Detes:	ar In U,S. 1	3. Was Decedent If Yes, specify	t of Hispenic Origin? (Cuben, Mexican, Pue No Specify:	Specify Yas or No rto Rican, etc.)	9- 14. Race - A Bleck, W Specify: W	mericen Indien, hite, etc. hite
Department of Health end Mental Hygiene. Important: If Item 27 is merked other than "natural", any injury or other traumatic event, the Medical Exe once.	Completed	15. Decedent's Edu (Specify only highest grad	cation e completad)	16e. De	cedent's Usuel C	Occupation done during most of wo ratired)	orking	16b. Kind of Busine	ess/Industry
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Health em 27 rther tr		James E. Groves, a		324	10 E, N	Northern Pa	irkway Ba	altimore,	Maryland
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Department Important: it any injury o		4 Donetion 5 Other (Spacify) 21. Signature of Funaral Service Licens		Lakevie		Address of Fecility	9/8/98	Eldersbur	g, Marylan
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has been sign ge 2 should be	Completed by				_			an autopsy 24 primed?	b. Were eutopsy findin eveilable prior to completion of cause of deeth?
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Director	10e. Street end Number		Baltim	10f. Zip Code			10g. Citizen of Wh	ot Countr	
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Funeral	11. Meritel Stetus	12. Wes Decedent Ex		3. Was Decedent of I	lispanic Origin? (S	pecify Yes or No	- 14. Race -		
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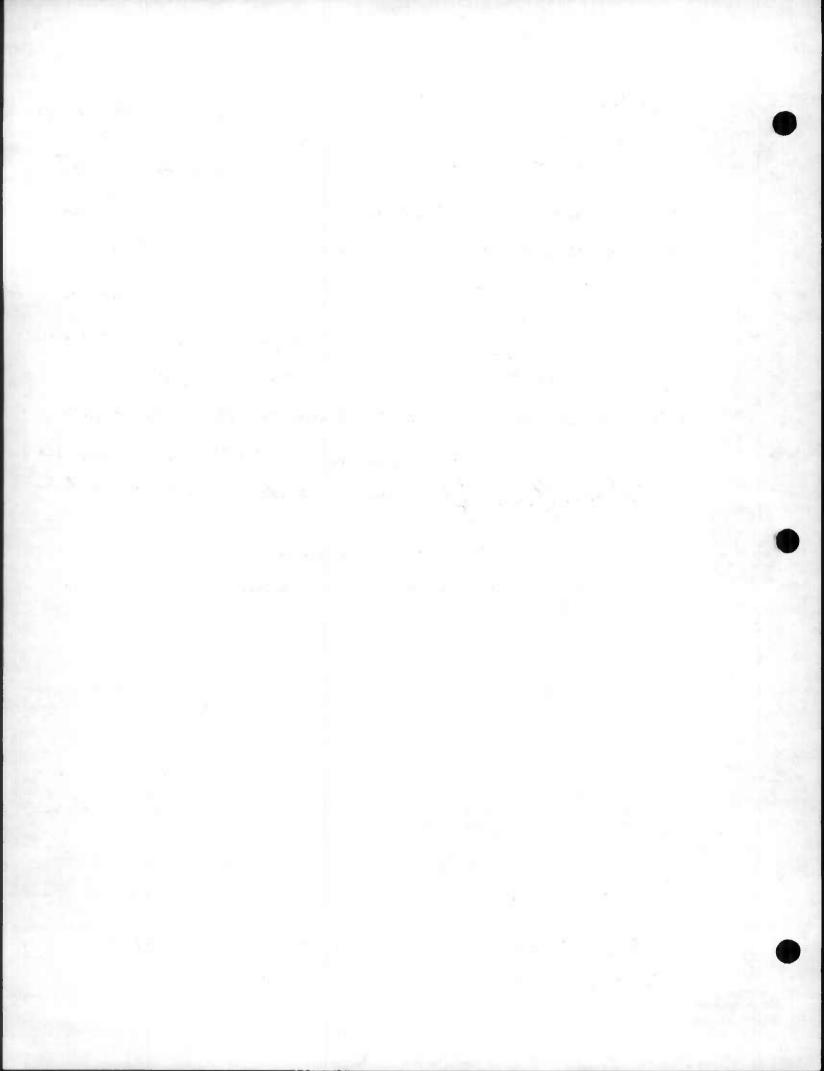
DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month Year Bullock 10 85/18 /Medical 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Ritchie Battemore Joseph House If Under 24 Hrs. 8. 5. Sociel Security Number If Under 1 Year 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign **Funeral** Year) +2 1₽M 2□ F Deys 219-40-7961 55 Yrs Director Usual Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryle Department of Health and Mental Hygiene. Important: If than 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Madical Examines must be notified any injury or other traumatic event, it is Madical Examines must be notified. MD Baltimore 1 Hes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21202 Street U.S.A. 815 Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) Race - American Indian, Bleck, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 Specify: Black 1 ☐ Yes 2 ☐ No þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupetion
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Battemore of Elementary/Secondary (0-12) College (1-4or 5+) Dept. Santitation 12th grade NA 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Brooks Bullock Jessie 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Asquith St., Batto, mo Bullock Caloria 20b. Place of Disposition (Name of 20e. Method of Disposition Dete 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Buriai 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1101 E. North EHST F. # March 23a. Pert1. Enter the disease, or complications that cause 1 he death Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each log. Approximate intervet Between Onset end Death **Physician** Immediete Ceuse (Finat disease or condition resulting in death) /Medical KLOS carrenana Examiner Due to (or as a consequence of) Physician/Medicai Examiner Car unama 0 Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Box 68760, Due to (or as e consequence of): P.O. I Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Dfd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy findings eveileble prior to completion of ceuse of deeth? Completed 24e. Wes en eutopsy performed? page 1 ☐ Yes 2 1 No 1 Yes 22 No certificate Be 25. Wes cese referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA Other: 4 Nursing Home 5 Residence 6 DOther (Specify) 1 Yes 2 No Medical Certification: To After this 28c. fnjury et Work? 27. Menner of Deeth 28d. Describe how injury occurred Hospital or Attending 1 Naturel 5 Pending Investigation death. 1 Yes 2 No 2 Accident s efter death 6 Could not be determined 3 SuicIde 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours e To the Funeral D 29a. Certifier 12 Certifying Phyeicfan: To the best of my knowledge, death occurred et the time, dete and piece, and due to the ceuse(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and piece, end due to the ceuse(s) end menner stated. 29b. Signature and ittle of ogittles 29c. License number 29d. Date signed (Month, Day, Year) 002250 sayed , MODO 30. Name and address of person who completed cause of death (tiem 23a) (Type, Print) 27 Linder Kee nel AVES nacy 31. Dete filed (Month, Day, Yeer) SEP 0 8 1998 32. Registrar's Signeture State Registrar

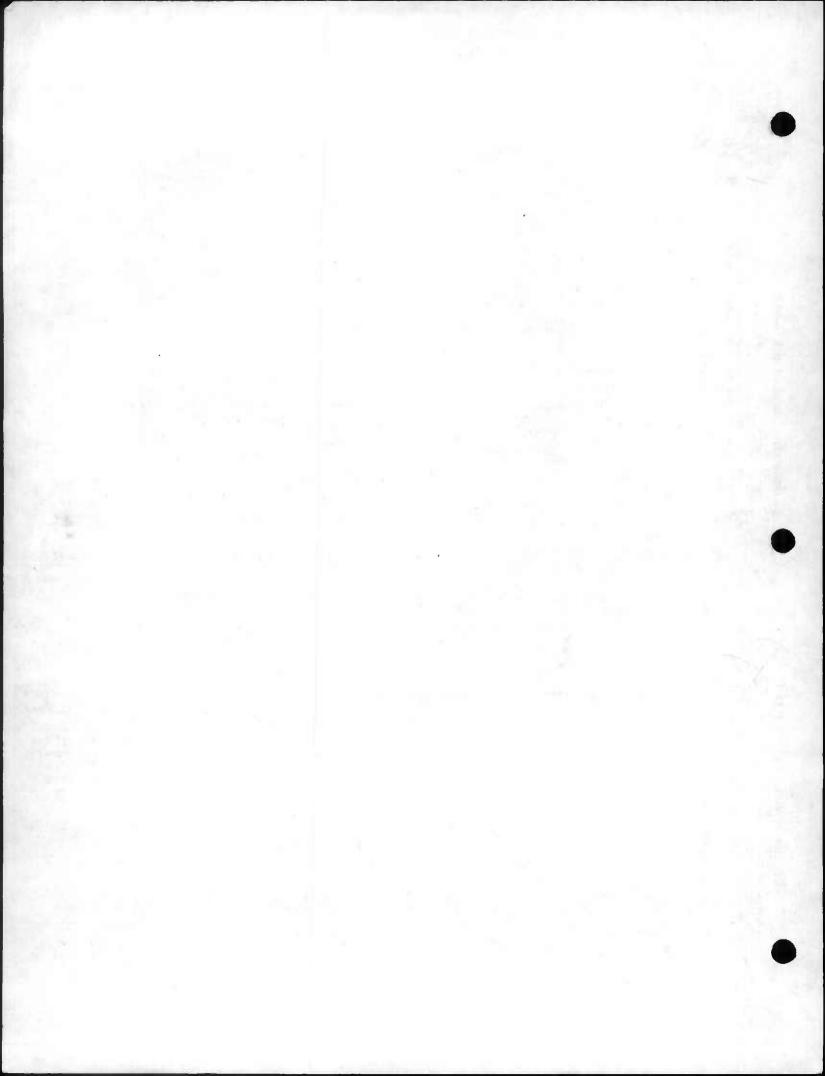


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** SEPT. 4, LOUISE A. BUSCHMAN 1998 11:57 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner DULANEY TOWSON NURSING HOME TOWSON BALTIMORE Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Months Deys 1 M 200/F 92 218-22-3875 MARYLAND Director Usuet Residence of Decedent the Maryland 10e State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Director MARYLAND BALTIMORE r 28a-f TOWSON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò "natural", or Nema 23e 1044 KENILWORTH DRIVE 21204 U. S. A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 Ø No If Yes, Give Yeer or Detes: 14. Race - American Indien. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) e filed within 72 hours after of al Hyglene. other than "natural", or flem rent, the Medical Examinar : Bleck, White, etc. 1 Never Merried 2 Merried altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: à WHITE 3 Nidowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) LEGAL SECRETARY LAW 12th GRADE 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be I Department of Health and Mental I Important: If Item 27 is marked of any injury or other traumatic eve JAMES KALOUS FRANCES SVATORA 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) F.GORDON BUSCHMAN (SON) 1044 KENILWORTH DRIVE. TOWSON, MARYLAND 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Date 1 ⊠ Buriel 2 ☐ Cremetion 3 ☐ Removel from State MOST HOLY REDEEMER 9/8/98 BALTIMORE, MARYLAND 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee SCHIMUNEK FUNERAL HOME INC. Buan 3331 BREHMS LANE, BALTIMORE, MARYLAND 21213 a 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) One day Examiner Examine AMPUTATION TWO week ABOVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of) SEVERE PERIPHERAL VASCULAR edical Due to (or es e consequence of) Physician/M Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably 4 DOnknown à 24a. Was an autopsy performed? 24b. Were autopsy findings eveilable prior to completion of cause of death? Completed 1 Yes 2 1 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) To Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 dursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 营 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury et Work? 28d. Describe how injury occurred Certification: Affin 5 Pending investigation 1 Natural 1 Tyes 2 No To the Hospital or Attends within 24 hours after death To the Funeral Director: A completely filled in by the f 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end place, and due to the cause(s) and menner as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier D50600 30. Name and address of parson who completed cause of death (Item 23a) (Type, Print) 2822 HollingFERRY ROAID Baltimore MD 21230 SIMIA SHIH

DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Day, Year)

32. Registrer's Signeture



98-5096-510

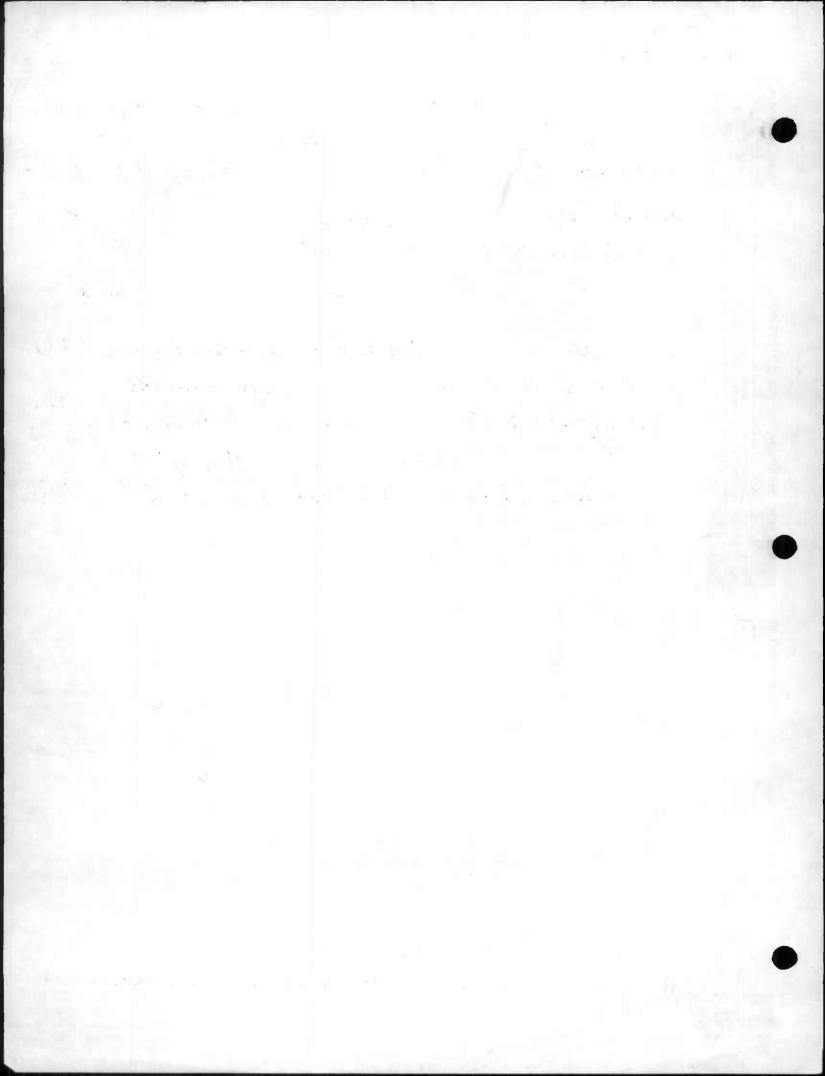
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WAYNE L. BROOKS

State of Maryland / Department of Health and Mental Hygiene

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п	Physician /Medical	Way	re Brook	KS		AUGUST		Yaar 198	2:00 A
ŝ	Examiner	4a Facility Nama (If not institution, give	street end number)		4b. City, Town, or		4c. County of		
		LIBERTY MEDICAL	CENTER		BALTIMOF	_		NIT	
	Funeral Director	5. Social Sacurity Number 6. Sec. 15 Usuel Rasidence of Decedent		Ast birthdey) If Under Months	1 Year If Under 24 Hrs Days Hours Min.		Year) 1954	9. Birthplace Country)	(State or Foreign
	Maryland -f show fled =	10a. Stata Maryland N/A	10c. City	Rown or Location	More				nside City Limits
	fter death with the Mai r items 23e or 28s-fe inc. ms. to notified Funeral Director	10e. Street and Number 3213 Vickers	Rd. 1st Fl	10f. Zip	2/2/le	11	og. Citizen of Wh	nat Country?	
020	by	11. Maritel Status 1 Navar Married 2 Merried 3 Widowed 4 Divorced	12. Was Dacedant Ever in U, Armed Forcas? 1 ☐ Yes 2 ☐ No If Yas, Give Year or Detas:	S. 13. Was Decedif Yas, specif Yas	dent of Hispanic Origin? (Scify Cuban, Maxican, Puer 2 PNo Specify:	Specify Yas or No- to Rican, atc.)		- Amarican In , White, atc.	idian,
21215-0020	ed within 72 hours ygiene. ver than "natural", nt, the wedies Ex- Completed by	15. Decedant's Edu (Specify only highast grad	a complated)	16a. Decedent's Usua (Giva kind of wo lifa. DO NOT us	rk dona during most of wo	rking	16b. Kind of Bus		
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Division of Vital	To the Hospital or Attending Physician: within 42 hours after death. To the Funeral Director: After this cartilica completaly filled in by the funeral director, Medical Certification: To Be C	2 Accidant invastigation 3 Suicida 6 ACould not be detarmined	FOUND: 8-30-98 28e. Place of Injury - At he building, atc. (Specify	me, farm, street, factor		28f. Location (St	raat and Numbe	r or Rural Ro BALTIMO	outa <i>Number</i> , DRF., MARYLAN
	he Hospital in 24 hours he Funeral plataty filled edical C	(Check only Medical Exami	RESI sician: To the best of my knowner: On the basis of axaminat	DENCE wledga, death occurred lon end/or investigation	at tha tima, data and place, in my opinion, daath occ	e, end due to the c	ausa(s) end men	nar es stated	d.
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		30. Name and address of person who co	mpletad cause of death (Item		Penn Street	, Baltimo	re, Mar	yland	21201
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DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Mary Month OU AM Blackwell September 1998 4e. Facility Name (If not institution, giva street end number) 4b. City, Town, or Location of Deeth City, Town, ... Balfmore If Under 24 Hrs. 8. Date of Birth Hours Min. 8. Date of Birth Myonth, Day, 4 - 24-4c. County of Death Mercy Medical Center Saint Paul Place 301 NA If Under 1 Yaar 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) 10 M 20 F Deys 214. 46.085 MD Usuel Residence of Decedent 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits BALTIMORE 12 Yes 2□No MO 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 4006 GELSTON RIVE 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puarto Ricen, atc.) Race - American Indian, Bieck, Whita, atc. 1 Never Married 2 Married 1 Yes 2 No Specify: BLACK 3 ₩idowed 4 Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life_DO NOT use retired) 15. Dacedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) College (1-4or 5+) DOMESTIC LIH GRADE NA HOME 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maidan Sumama) MINNIE RODGERS LAWRENCE EDWARD 19e. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 4006 GELSTON BALTO MD JAUGHIER 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, Steta 1 Buriel 2 □ Cremetion 3 □ Removel from State 9.5.48 BALTO. 4 ☐ Donetion 5 ☐ Other (Specify) RESTLAWN CEMETERY 21. Signatura of Funere/Service Licensee 22. Name end Address of Fecility FUNERAL SER VAUGHN C. GRÉENE 5151 BALTO. NATL' PIKE BALTO. 21229 23a. Pert1. Enter the disease, or complications that ceused the deeth. Do not anter the mode of dying, such as cerdiac or raspiratory errest, shock, or heart failure. List only one ceuse on each line. Approximate Intervel Between Onset end Deeth Preumoperitoneum Immediete Ceuse (Final diseese or condition resulting in deeth) Ulcan eptic Due to (or es e consequence of): Due to (or as a consequence of): 23b. Did tobecco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown Altheimer's 24a. Was en autopsy performed? 24b. Were eutopsy findings eveilable prior to completion of ceusa of deeth? 1 Yes 25. Wes case referred to medical exeminer? 26. Place of Death (Check only one)

Physician /Medical Examiner

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signed by the et d be deteched for

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Division of Vital

Examiner

Physician/Medical

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/Medical

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7 is marked other than "naturel", or Items 23s or 28a-f show traumstic event, the Medical Examinar must be notified at

other

Injury or Depertment of Important: If any Injury or Office.

Peges 1 and 2 should be filed within 72 hours after of tent of Health end Mental Hygiene. nt: If Nem 27 is marked other than "naturel", or Nei

Baltimore, Maryland 21215-0020

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death

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initieted events rasulting in deeth) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Inpatient 2 ER/Outpetient 3 DOA 28c. Injury et Work? 28b. Time of 5 Pending

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29b. Signeture end title of certifier

31. Dete filed (Month, Dey, Yeer)

27. Menger of Deeth

1 Neturel 2 Accident

3 Suicide

29a. Certifier

4 Homicide

Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the ceuse(s) end menner es steted. ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end placa, end due to the cause(s) end manner steted. 29c. License number 29d. Data signed (Month, Dey, Year)

investigation

6 Could not be determined

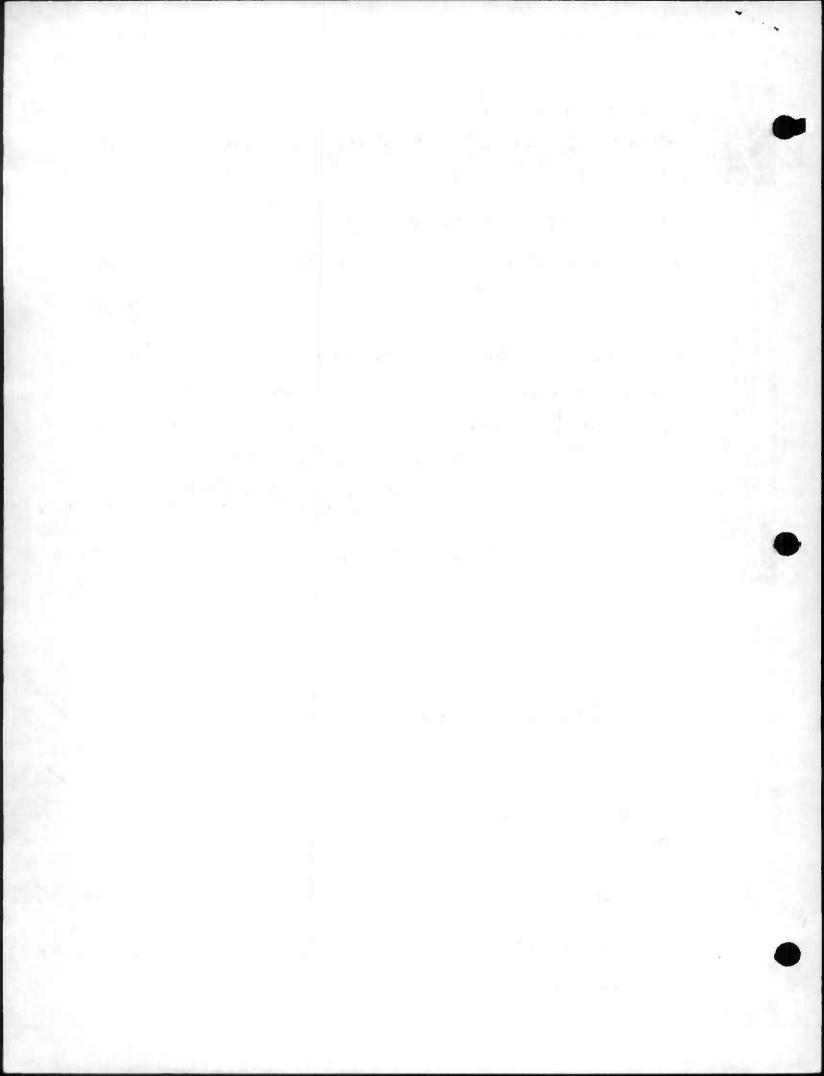
30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Keith Lee South Greene Street

SEP 0 8 1998

32. Registrat's Signeture

Baltimore, Maryland

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Dey Yeer SEPTEMBER 7, 1998 **Physician** PEARL M. BARRETT 1:00 A.M. /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 7657 RIDGE RD. HANOVER ANNE ARUNDEL 5. Social Security Number 7. Age (In vrs. last birthday) if Under 1 Year | if Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) FEB. 6, 1933 9. Birthplece (Stete or Foreign **Funeral** Months 1 M 2 F Devs Hours Country) MARYLAND 65 212-30-1571 Director Usuel Residence of Decaden with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at MARYLAND ANNE ARUNDEL HANOVER 1 ☐ Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 7657 RIDGE RD. 21076 UNITED STATES Funeral death 12. Was Decedent Ever in U,S. Armed Forces?
1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, 11 Marital Status Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene.
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KIRKLEY-RUDDICK FUNERAL HOME, P.A. 21. Signal e of Furnism Service Licenses 421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Finel diseese or condition resulting in deeth) Examiner 0 Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of) edical Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. Physi 1 Yes 2 No 3 Probably 4 Unknown 2 bengs be dg à 24b. Were eutopsy findings eveilebie prior to completion of cause of deeth? Completed 24a. Wes en eutopsy page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) 88 Other: 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA mis 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28e. Dete of Injury (Month, Dev Year) 28c. Injury et Work? Certification: 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident after death Director: 3 ☐ Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 24 hours a 24 hours e Funeral 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end plece, end due to the ceuse(s) end menner stated. 29e. Certifier edical (Check only one) To the within 2 To the 29d. Dete signed (Month, Dev. Year) 29b. Signature and title of certifie 29c. License number SEPTEMBER 8, 1998 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) MARCELINO D. ALBUERNE, M.D., 1120 N ROLLING RD., CATONSVILLE, MD 21228

DHMH 16 Rev 6/95

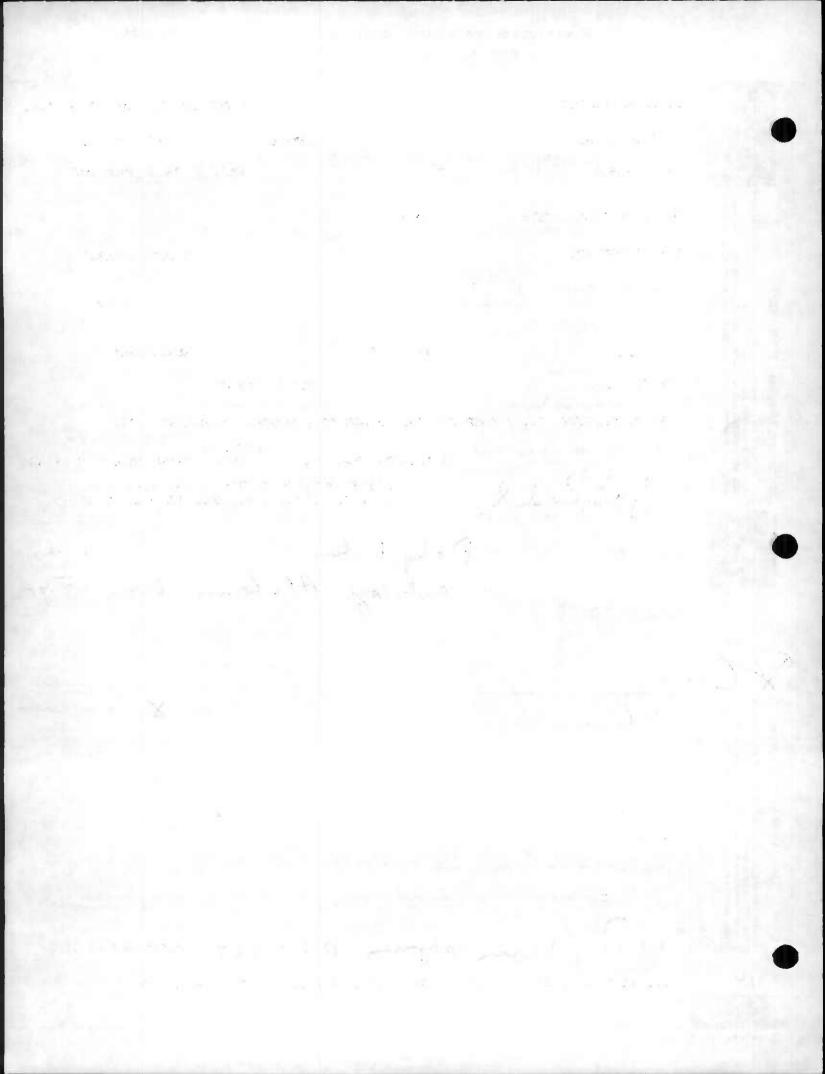
State

Registrar

31. Date filed (Month, Day, Year)

SEP 0 8 1998

32. Registrer's Signeture



State of Maryland / Department of Health and Mental Hygiene 3 7 2 6 7

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	ITEMS:	#23	PART	I,	27	PER	MEO	G763	9-14-98	WR.

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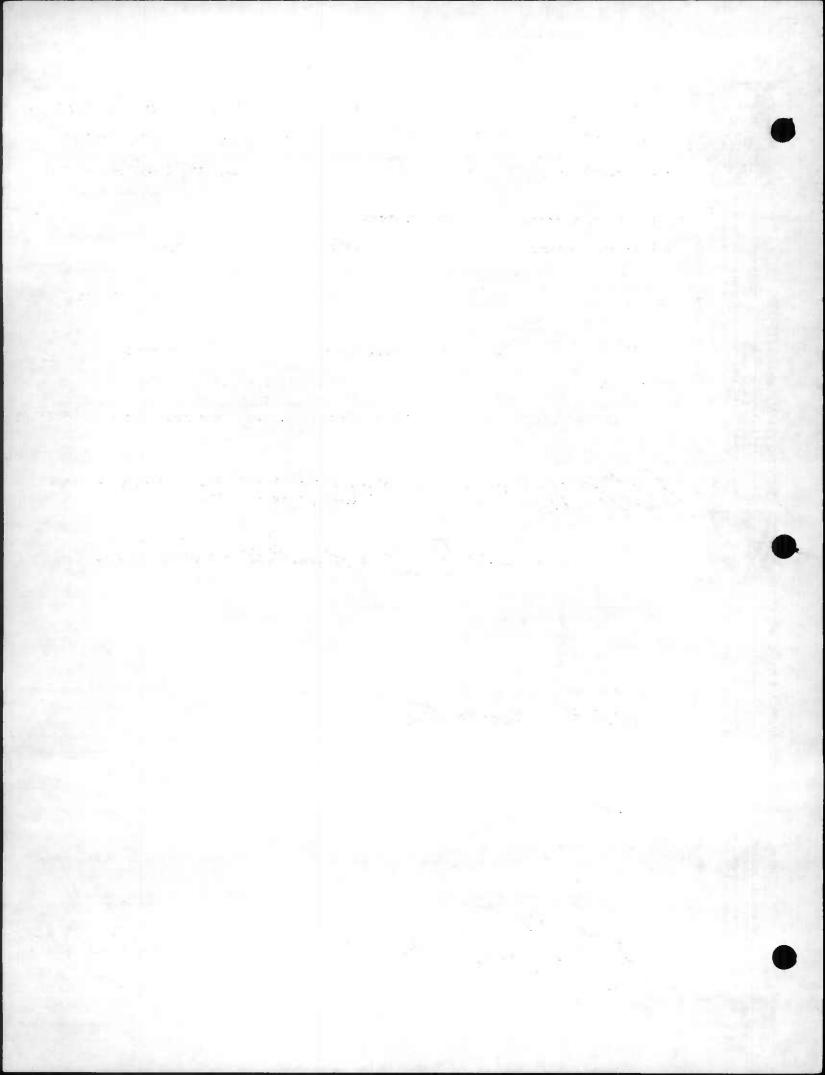
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death Day Month **Physician** BROOKS 20, 1998 AUGUS /Medical 4e Facility Nema (If not institution, giva street and number, 4b. City, Town, or Location of Death 4c. County of Deeth Examiner SHADY GROVE ADVENTIST HOSPITAL MONTGOMERY ROCKVILLE 8. Date of Birth (Month, Dey, Year) Dec. 18, 1905 Pennsylvania If Undar 1 Yaar If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthdey) 92 yrs Birthplace (State or Foraign Country) **Funeral** Months 1 □ M 25 F Days Hours 577-60-2740 Director Usual Residence of Decedent Pages 1 end 2 should be filled within 72 hours after death with the Meryland nent of Health and Mentel Hygiene. International terms 23s or 28s-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Example: must be notified at 1 Yes 2 No Maryland Montgomery Gaithersburg Directo 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 301 Russell Avenue 20877 U.S.A. Funeral 12. Was Decedanf Evar in U,S. Armed Forcas? Was Dacedanf of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, afc.) 14. Race - Amarican Indian. 11 Marital Status Black, Whita, atc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yes 2 ₹No Specify: Specify: White þ 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondery (0-12) College (1-4or 5+) Insurance Secretary 7 is marked other traumatic event, i 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First Middle Maiden Surneme) Be David Meigs Lillie Dunn 19a. Informant's Name/Reletionship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Ethel Rathgeb/cousin 356 North Main Street, Greenburg, Pennsylvanial 5601 Department of Health Important: If Item 27 any injury or other to 20b. Pieca of Disposition (Neme of 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cramation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) Rona Ld 22 State Anatomy Board, 655 W. Baltimore Street Wade, Director Baltimore, Maryland 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hear feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner requires that the death certificate be executed physician end s the burial-trensit Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): attending physical designation of the state signed by the at d be deteched for Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably Junknown 1 Yes 2 No þ 24b. Were autopsy findings available prior to 24a. Was en autopsy performed? Completed completion of cause of death? page 2 188 3 No 1 ☐ Yes 2 ☐ No certificate Hospital or Attending Physician: funeral director, Be 25. Was case referred to medical exeminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To Inpatient 2 ER/Outpetient 3 DOA After this 27. Manner of Deeth 28d. Describe how injury occurred 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. injury et Work? 1 Naturai 5 Pending efter death. Director: Aft 1 ☐ Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Pleca of Injury - Af home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) by 4 Homicide 24 hours e Certifying Physiciany To the best of my knowledge, death occurred at the time, date and place, and due to tha ceuse(s) and menner es steted. [2] Medical Examiner: but the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and manner stated. 29a. Certifier Medical To the Hosp within 24 hor To the Fune completely fi 29b. Signature a 29d. Date signed (Youth, Day, Year) 29c. Licansa number

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32. Registrar's Signature

State Registrar



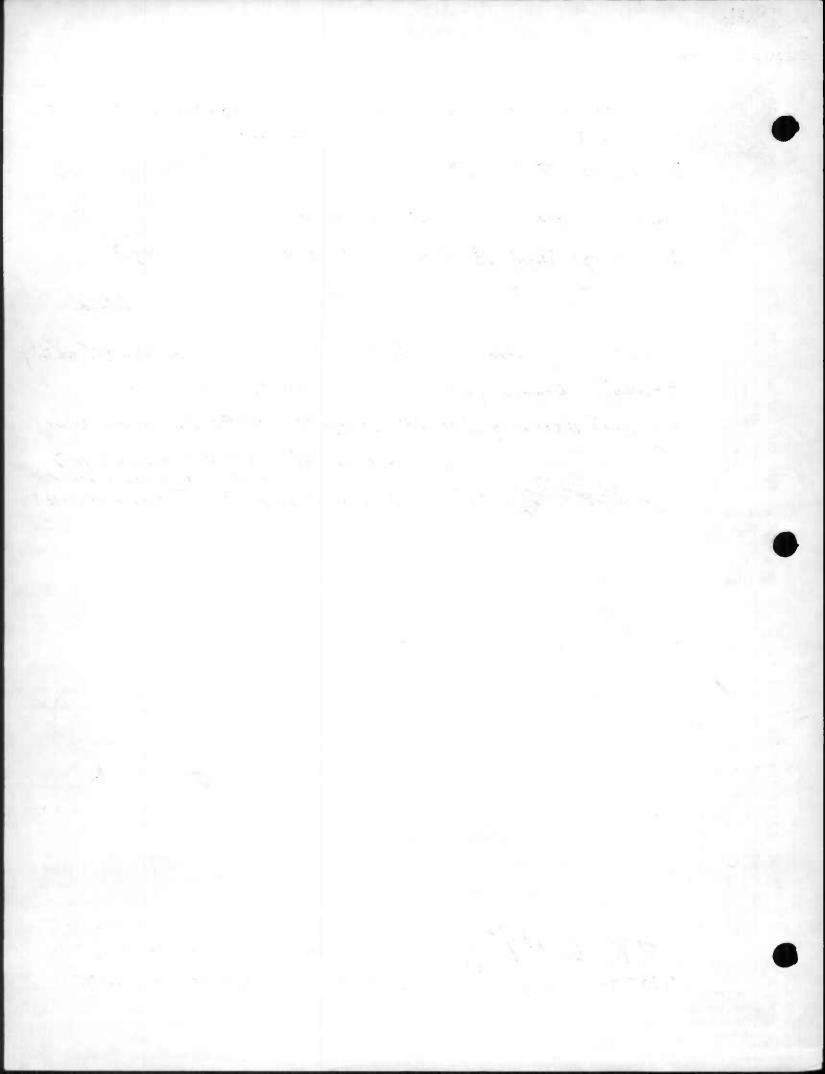
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Physicia: /Medica	-	Decedent'e Neme (First, Middle, Last) HERMAN	COLLINS	AU	GUST 29	1998	3. Time of Death 2:00 A.M.
Examine Funeral Director		221-12-0641	lest birthdey) If Under 1 Yeer Months Deys	4b. City, Town, or Location of BALT! HO If Under 24 Hrs. Hours Min. SE	RE e of Birth onth, Dey, Year)	Ounty of Deeth A / A 9. Birthp Cour V L A	Olece (State or Foreign oltry)
nd 21215-002 be filed within 72 hours e lel Hygiene. I other than "natural", overt, the Medical Exam	To Be Completed by Funeral Director	MARYLAND 10e. Street end Number 19 11 MC CULLOH STREE 11. Merital Stetus 1 Never Merried 2 Married 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) WILLIAM 19e. Informent's Name/Relationship (Type, Print) LUCILLE COLLINS DAUGHTER 20b. Method of Disposition 1 Burlel 2 Cremetion 3 Removel from Stete 4 Donation 6 Other (Specify) 21. Signature of Funeral Service Densee	10f. Zip Code 10f. Zip Code 11 13. Wes Decedent of If Yes, specify Cul 1 Yes, specify Cul 1 Yes 2 No 16e. Decedent's Usual Occu (Give kind of work done life. Do NOT use retin 1 A BOR 19b. Meiling Address (Street) 19b. Meiling Address (Street) 19 11 M C Cup Plece of Disposition (Name of cemetery, crematory or other pix 17. ZION CEME 2005 EPH Address 2140 N. F	petion during most of working dol 201 18. Mother's Neme (First, MARY and Number of Flural Route (First) LLOH STREET (Page) Determine the property of the pr	s or No- etc.) 16b. Ki Hc Middle, Maiden Number, City of 20c. Lo 98 LA JNERAL H BALTIM	zen of Whet Cour USA 14. Reca - Amerik Bleck, White, Specify: BL nd of Business/in OCHSCH Sumame) r Town, State, Zip I HORE, H cation - City or To NSDOWN OME, P.A.	can Indien, etc. ACK dustry ILD KOHA Code) 10.2/2/7 Dwn, Stete LE, MD.
Attending Physician: The law requires that the death certificate be order. The death. Sector: After this certificate has been signed by the ettending physicial by the funeral director, page 2 should be detached for use as the but the funeral director.	Certification: 10 Be Completed by Physician/Medical Examiner	Sequentially list conditions, if erry, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that inflicted events resulting in death) Lest Pert II. Other significant conditions contributing to death but not reconstructed and the conditions contributing to death but not reconstructed and the conditions contributing to death but not reconstructed and the conditions contributing to death but not reconstructed and the conditions contributing to death but not reconstructed and the conditions contributing to death but not reconstructed and the conditions contributing to death but not reconstructed and the conditions contributing to death but not reconstructed and the conditions contributing to death but not reconstructed and the conditions contributing to death but not reconstructed and the conditions contributing to death but not reconstructed and conditions contributing to death but not reconstruct	pr as a consequence of): or as a consequence of): ar as a consequence of): definition of linjury of the content of the cont	bras Grand G	a. Wes en autoperformed? Lessidence (specific how injured)	usa contribute to No 3 Pro 24b. We expended to the contribute to	o the cause of deeth? bably 4 Unknown ere autopsy findings elleble prior to impletion of cause deeth? Yes 2 No
To the Hospital or within 24 hours effe To the Funeral Dir completely filled in	Medical C	29e. Certifier (Check only one) Certifying Physician: To the best of my kni (Check only one) Medical Examiner: On the best of examiner and manner stated. 29b. Signeture end title of certifier 30. Name and express of person who completed cause of deeth (Iter	ation end/or Investigation, In my	opinion, deeth occurred et the	e time, date and	place, end due to e signed (Month,	Dey, Year)
State Registrar		31. Dete filed (Month, Day, Year) SED 0.8 1000	2.D. 44571	KENWOU	PAHVE	·BA	40313

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend: #22 Per FH Film G763 9-8-98RC Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 08 ord+s /Medical AN 4a. Facility Name (If not institution, giva street and number) City, Town, or Location of Death 4c. County of Death **Examiner** Schmir Under 24 Hrs. 8. Da HOSDICE 6. Sex If Under 1 Yaar If Under Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, 9. Birthplaca (State or Foreign Country) **Funeral** Days Min. 215-38-2782 Usual Residence of Decedent 1 M 2 F 59 Months Hours Yrs. Director death with the Maryland 10a. Stata 10c. City. Town or Location or items 23a or 28a-f show 10d. Inside City Limits 1 ☐ Yes 2 No Director the Medical Examiner must be notified maso 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2103 748 Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☑ No 13. Was Decedant of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Maxican, Puarto Rican, etc.) 11 Marital Status 14. Race - American Indian Black, White, etc. filed within 72 hours after 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2NNo Yes. Give Specify by Specify: 3 Widowed 4 Divorced Year or Dates natural', Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Goorge Hygiena. Elementary/Secondary (0-12) College (1-4or 5+) Director other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Health and Mental Helen important: If Item 27 is marked Harold 2 nen Kidge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rugal Route Number, City or Town, State, Zip Code) Valhala 21035 Husband phoale 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Pages Department of h 1 ☐ Burial 2 ☑ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dollimore, LREMITOR lanulan 22. Name and Address of Facility House Of ure of Funeral Sarvice Licensee Hricks 4 Forest Dr. Annapolis, Md Md. 21213 1639 N. Broodness Julio. 23u. Part Lefur the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final 2 405 disease or condition resulting in death) Examiner Due to (or as a consequenca of) Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last pod Due to (or as a consequenca of): that the death certificate be execu-P.O. Box 68760, the Dua to (or as a consequence of): attending phys 88 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by the should be detach 1 ☐ Yas 2 ☐ No 3 Probably 4 Unknown Records, py The law requires Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 s 1 Yes 2 NO 1 ☐ Yes 2 ☐ No cartificata director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Tother (Specify) Hospice 2 ER/Outpatient 3 DOA Manner of Death

Division of Vital Hospital or Attending Physician: Certification: To funeral After To the Hospital or Attending within 24 hours aftar death.

To the Funeral Director: Afta completely filled in by the fur

edica

State

Registrar

29a, Certifier 12 Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29b. Signature and title 29c. Licensa number 29d. Date signed (Month, Day, Year)

28c. Injury at Work?

1 Yes

2 No

28b. Time of

(Type, Print)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

Location (Street and Number or Rural Route Number, City or Town, State)

31. Date filed (Month, Day, Year) 0 8 1998 SEP

1 Natural

2 Accident 3 Suicide

4 Homicide

30. Name and a

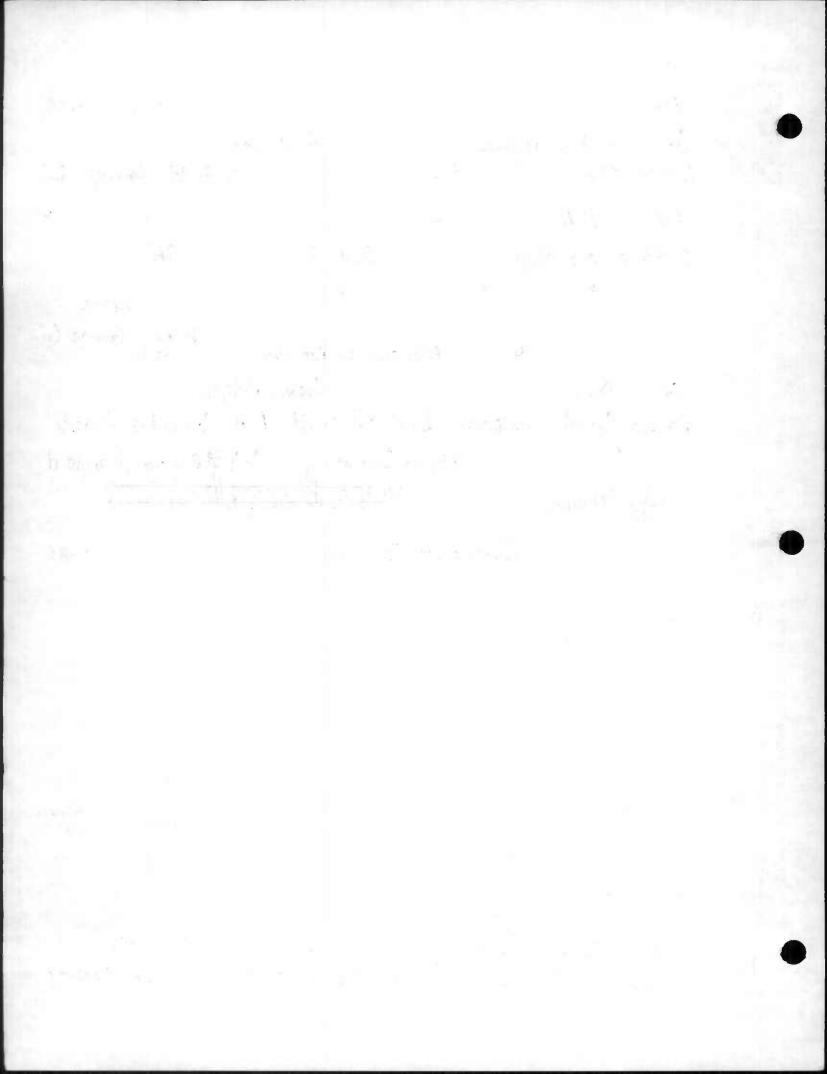
5 Pending Investigation

6 Could not be determined

32 Registrar's Signature

d cause of death (In

28a. Date of Injury (Month, Day Year)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Dete of Deeth 3. Tima of Death 1045 Month **Physician** Dm 4b. City, Town, or Location of Death MARGIE 260 CARTER /Medical 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner NA BALTIMORE If Under 24 Hrs. 8. BAYVIEW MEDICAL ENTER 8. Data of Birth (Month, Dey, 2-26- Birthplaca (Stata or Foraign Country) 5. Social Security Number 6. Sax 7. Aga (In yrs. lest birthdey) 10 M 20 F Months Days Hours Min. 220-76-7432 Usual Residence of Decedent Yrs. MO 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 □ No NIA BALTIMORE Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? USA MILFORD 21207 UENUE Funeral 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Datas: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Marriad 1 Yes 2 No Specify: BLACK P 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 16b. Kind of Business/Industry 15. Decadent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) JOMESTIC. GRADE NIA HOME 18. Mothar's Name (First, Middla, Maidan Sumame) 17. Fathar's Nama (First, Middla, Last) Be NORMAN MAE HINLEY 2 HOMAS TRANKIE 19b. Melling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) 4413 FALLS BRIDGE BALTO. MO. MOTHER TRANKIE 1HOMAS 20b. Pleca of Disposition (Neme of cametery, cremetory or other plece) Data 20c. Location - City or Town, Steta 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 9-2-98 BALTIMORE, MD 'EMELERY 4 □ Donation 5 □ Other (Specify) 21. Signature of Funerel Service Licenses 22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVICE 23a. Part1. Enter the diplese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. 21229 BALTO. MO. Approximate Intervel Between Onset and Death Immediate Cause (Final disaese or condition resulting in death) Immunodeficiency Syndrome 4 cquired Due to (or as e consequenca of): Examiner ardiciascular Accident Due to (or as a consequence of): Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury Presumed Central Newous System Vasculitis Physician/Medical that initieted events resulting in death) Last Dua to (or as a consequanca of) 23b. Did tobecco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying causa given in Pert I. 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was en autopsy performed? 1 ☐ Yes 2 12 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 11 H6 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 27. Manner of Death 28a. Dete of Injury (Month, Dey Year) 28h Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 PNatural 5 Pending investigation 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) IA 2 □ No 1 TYes 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Roula Number, City or Town, Stefe)

physician and the burial-transit The law requires that the death certificata be axecuted Box 68760. Division of Vital Records, P.O. or Attending death.

Funeral

Director

"natural", or items 23s or 28s-f show

Pages 1 and 2 should be filed within 72 ho nent of Health and Mental Hygiene. ant: If them 27 is marked other than "natur ury or other traumatic event, the Medical

permit. Pages 1 and 2 s
Department of Health an
Important: If them 27 is 1
any injury or other trausonce.

Physician

/Medical

Examiner

the Manyland

72 hours after death with

attending p 88 signed by the a been signated page 2 s has certificate this funeral After Director: / To use within 24 hours and To the Funeral Directory

State

Registrar

29b. Signature and title of certified

29c. License number

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date end plece, end due to the causa(s) end menner es stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and pleca, and due to the cause(s) and menner stated. 29d. Date signad (Month, Dey, Year)

d address of person who completed cause of death (Item 23a) (Type, Print) atrica Dardutch

WEIBURN Rd.

21237

31. Data filed (Month, Dey, Yeer) 0 8 1998

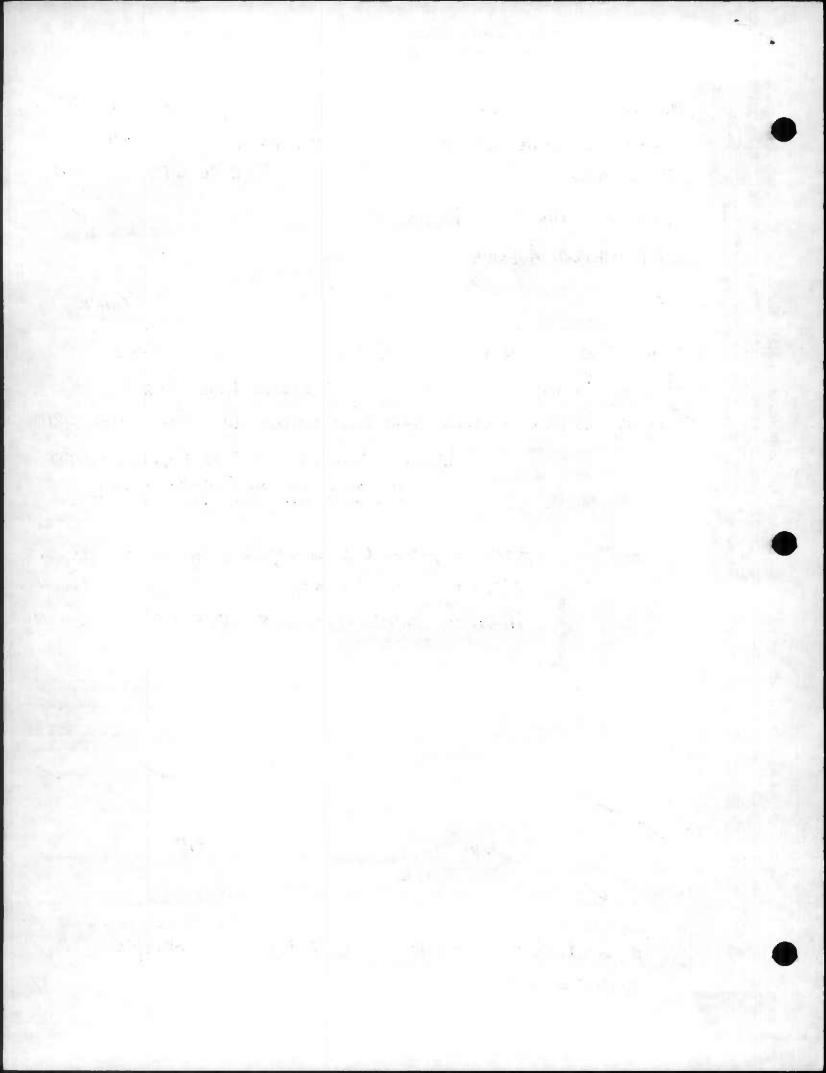
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(Check only one)

29e. Certifier

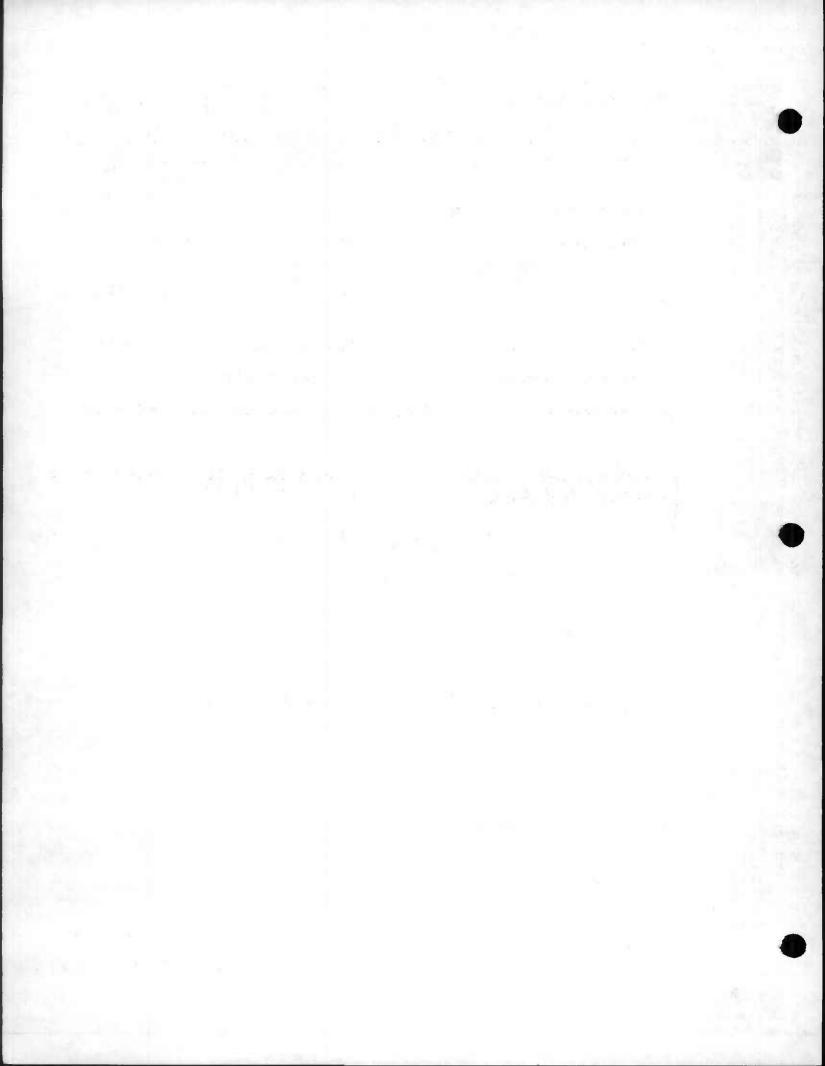
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32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	y - At home, f (Specify)	arm, street,	factory, office			(Street end Numb wn, Stete)	ber or Rural Route Nu
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P 0 ≥ 29b	b. Signature and title of certifier	MD.			29c. Licens	se number - 38-7	54.	29d. Data signe	d (Month, Dey, Year) 30 - 98
30.	Neme end eddress of person who c	completed ceuse of dea		(Type, Prin	BAST	TERN	BLVD	, M7	30-98

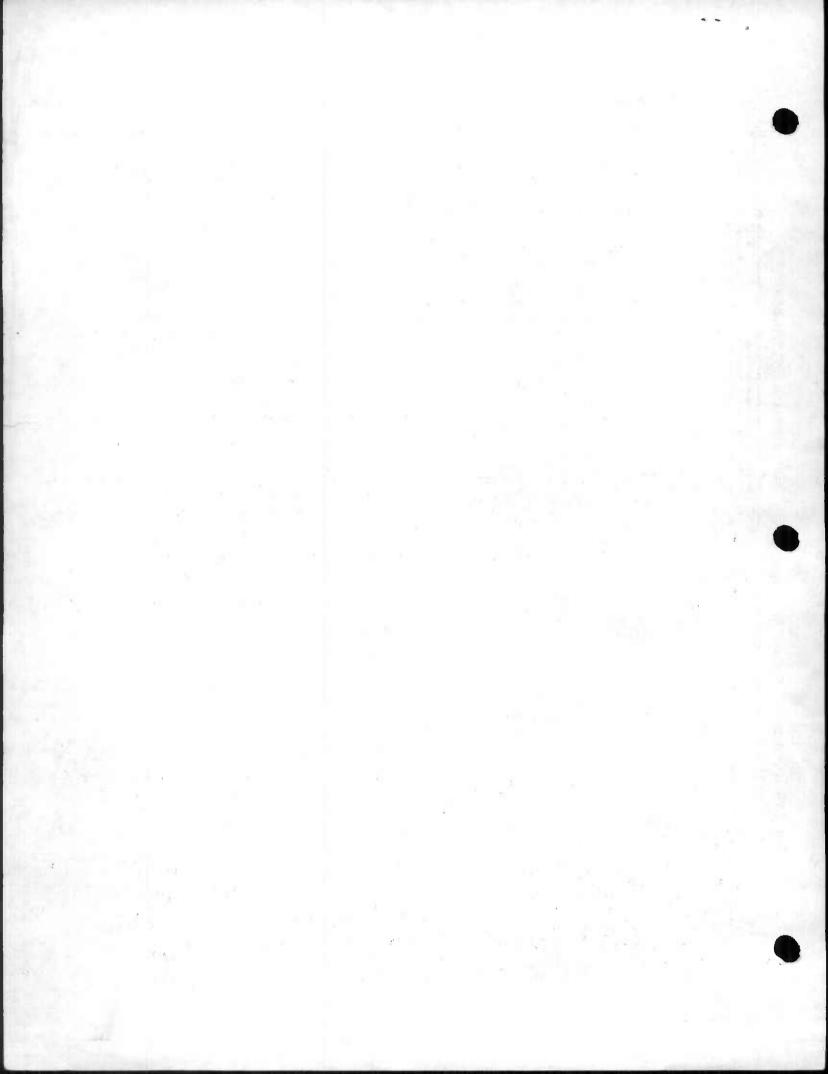


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	Decedent's Name (First, Middle, L.	nef)	Certii	ficate of	Death	2. Dete of Des	leg. No.	3. Time of Death		
Physician	RAYMOND	LEOPOLD	CL	EMMENS	6	Month	Dev			
/Medical Examiner	4a Facility Name (If not institution, gi Saint Joseph	re street and number) Medical Cen	ter		Ib. City, Town, or TOWS		4c. County of			
Funeral Director		Sex 7. Age (In yrs		Under 1 Year lonths Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day April	7, Year) 2, 1922	Birthplace (State or Foreign Country) Maryland		
the Maryland 28e-f ahow nothing at	10m. State 10b. County Maryland Balti		ity, Town or Locati	on				10d. Inside City Limits 1 ☐ Yes 2 ☐ No		
E 0 0	10e. Street and Number 522 Goucher Bou	levard		10f. Zip Code 21286	5		U.S.A.	het Country?		
by by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in I Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates: 1942	10	Decedent of Hes, specify Cube	ispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race Black Specify:	- American Indien, t, White, etc. White		
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M doth	17. Father's Name (First, Middle, Last Theodore C. C.					ne (First, Middle, Robert)		
PEE	19a. Informant's Name/Relationship				end Number or Ro Boulevar					
permit. Pages 1 end 2 Department of Health 1 Important: If Item 27 is any Injury or other tra anda.	20a. Method of Disposition 1 Burial 2 Cremation 3 [4 🖾 Donation 5 Other (Speci	Removal from State	Place of Disposition cometery, cremeter		ce)	Dete	20c. Location - 0	City or Town, Stete		
permit. Pa Departmen Important: any injury	21. Sometiment Emplaid Service-Lige	de Director			sof Facility Boa , Maryla		W. Balti	imore Street		
Physician end Examiner Color Examiner Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b	or as a consequer	nce of):	, VAS COL	AR DISC	ASE	YEARS		
E 0.0	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as e consequen	ce of):						
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The law requires that the death cariff sate has been signed by the attending page 2 should be detached for use a Completed by Physician/Me	CONGESTIVE CAR	DIS MYOPATHY				1 🗆 \		3 Probably 4 Unknown 24b. Were autopsy findings		
The law require						perior	med?	aveilable prior to completion of cause of deeth?		
yaiolan: The law is centificate has director, page 2 To Be Comp	25. Was case referred to medical				26 Place of Dec	ath (Check only o		1 ☐ Yes 2 ☐ No		
ding Physician: h. After this certific funeral director, tlon: To Be (examiner? 1 Yes 2 No 27. Manner of Death 1 Watural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	lome 5 ☐ Resid						
To the Heapital or Attanding Phywithin 24 hours after death. To the Funestal Director: After thi complising filled in by the funestal Medical Certification: 7	3 Suicide 6 Could not be determined	Ogo Diago of Intimy As h	nome, farm, street, ify)	factory, office		28f. Location (5 City or Tow	ocation (Street and Number or Rurel Route Number, lity or Town, State)			
he Hospita in 24 hours he Fumers pleasy fills edical C		yuician: To the best of my known on the basis of examination and manner stated.								
within To the comp	29b. Signature and title of certifier	orefu		29c. Licens	e number		29d. Date signed 8/21	(Month, Day, Year)		
	BARRY JOSEPHS	ompleted cause of death (its M. D., 7620	m 23a) (Type, Prir YORK R	DAD TO	WSON, MA	RYLAND	21204			
State Registrar	31. Date filed (Month, Day, Year) SEP 0 8 1998	32. Registrar's Sign	ature 4	backs	,					

DHMH 16 Rev 6/95



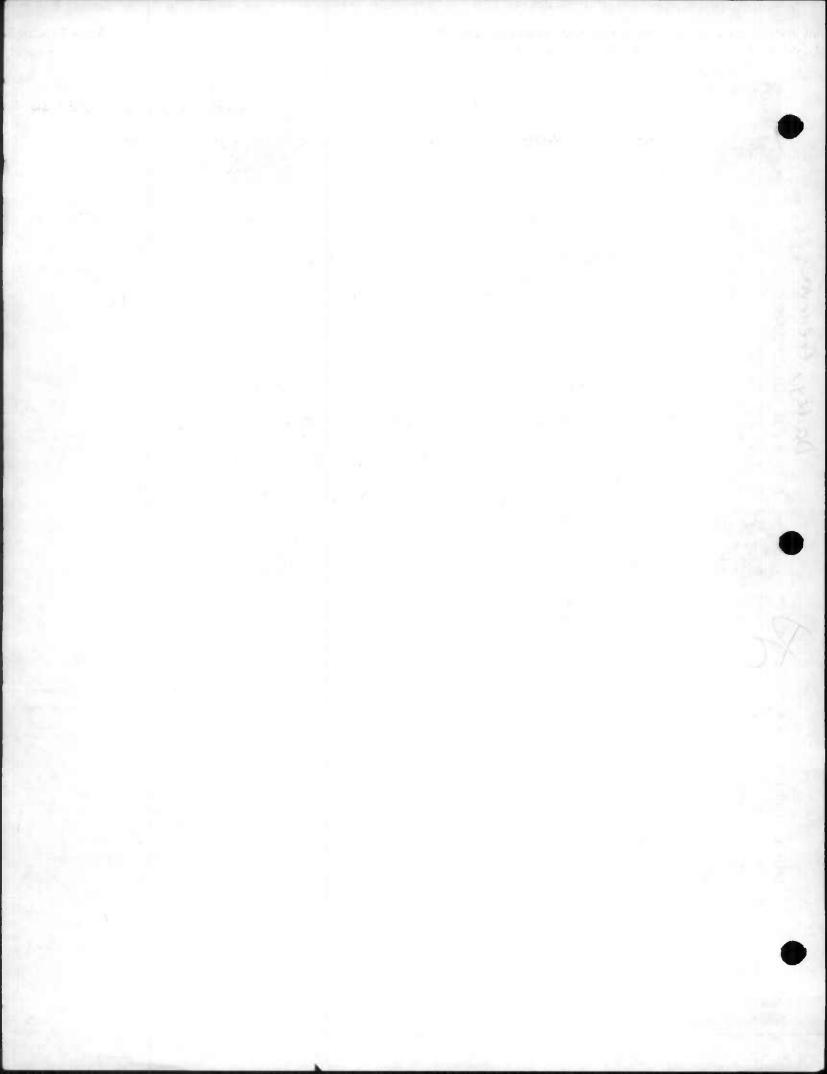
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2727

Physiciar /Medica Examine					Cer	rtificate	OT L	Jeath		Reg. No.	(iiia	1 1000
		1. Decedent's Neme (First, Middle, L GENEVA BR	ast) ACEY	DAILE	Y		П		2. Date of De Month	Dey	Year 998	3. Time of Deeth
	r	4e. Fecility Nema (If not institution, gi		mber)			41	b. City, Town, o	r Location of Deat			5074
			OSPICE	AT ME	RCY			BALT			N/A	
neral			Sex 1□ M 2□ F	7. Age (In yrs.	The second second	If Undar		If Undar 24 Hr Hours Min	Month, De	ev. Year)	9. Birthple Country	ce (Stete or Fore
ector	-	223 30 2003	- W - X	63	Yrs.				JULY	29, 19	35	MD
-	-	Usuel Residence of Decedent 10e. Stete 10b. County		10c Gi	ty, Town or Lo	cation					100	d. insida City Lim
be notified at	ğ	,	N/A		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		BALT	0.			100	XX Yas 2□
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miner	Funeral Director	1 ☐ Never Merried 2 ☐ Married	Armed Fo	rces?	1	f Yas, speci	fy Cubar	n, Mexican, Pue	into Rican, etc.)	Bla	ck, Whita, at	c.
9 .	2	3√DWidowed 4 □ Divorced	If Yes, Giv	/8		1□ Yes 🕺	EXNo	Specify:		Specify	BLAC	K
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-		LINDA ROSEBORO							Rural Route Numb			
other tr	-		JUGH	00h				OD RD		TO, MD	2123	
6		20e. Method of Disposition 1 ☑ Burial 2 ☐ Cramation 3 (Removel from	State	Plece of Dispo cametery, crem	netory or oti	har plece	C EM	9-5-98	TTMON		
any injury or conce.	1	4 ☐ Donation 5 ☐ Other (Special			LANEY			MEM				ע
any inj		21. Signature of Fuheral Service Lice	onsee / /	2	22	. Name end	Addras	s of FecilityBI	ETTS FU	NERAL H	HOME	
# 9		+ Hotheria	45	1/2		1129	N.	CAROL	NE ST	BALTO,	MD 2	1213
Medical Examination	ical Examiner	resulting in death) Sequentielly list conditions, if eny, leeding to immediata cause. Enter Underlying Cause (Disease or Injury fhet Initiated events resulting in deeth) Lest	b	Due to (d	or as e conseq or es e conseq or es a conseq	uance of):						
	rnysician	Pert II. Other algnificant conditions	dcontributing to de	eath but not ras	sulting in the ur	nderlying ca	use give	in In Pert I.		tobacco use co ∑es 2⊡ No		
page 2 should										s en eutopsy ormed?	com	a autopsy findin eble prior fo pletion of cause eth?
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ral director,	0	axaminer? 1 ☐ Yas 2 ☑ No	Hospital:	npatient 2	ER/Outpetien	it 3□ DO/	Othe	r: 4 Nursing	Home 5 ☐ Res		er (Specify)	
9 2		27. Mannar of Death 1 Maturel 5 □ Pending 2 □ Accident Investigetic		of Injury h, Day Year)	28b. Time of Injury	M 28	c. Injury Work	et ? /es 2 \sum No	28d. Describe	how Injury occur	red	
m 1 🛳	cermics	3 Suicida 6 Could not I datermined	28e. Plece	of Injury - At h ng, etc. <i>(Speci</i> i	ome, ferm, str	eet, factory,	office			(Street end Numb wn, Stete)	bar or Rural	Routa Number,
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Completely filled in by the fr	medical	(Check only one) 2 ☐ Medical Exa 29b. Signature and fitte of certifiar 30. Neme end address of person who	end mani	nom	n 23a) (Type,				Delgin Re MD =			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Dete of Deeth Month OVELEN 4e. Fecility Neme (If not institution, giva street and numbar) 4b. City, Town, or Location of Death 4c. County of Death N/A If Under 24 Hrs. 5. Social Security Number 9. Birthplace (Stete or Foreign Deys 1 M 280 F 219-28-0040 1935 Maryland Usuel Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits N/A Baltimore 12 Yes 2 No 10e. Street end Number 10f. Zip Coda 10g. Citizen of Whet Country? 2848 Edgecomb Circle South 21215 U.S.A. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - American Indian, Black, Whita, atc. 1 ☐ Yes 2 ☐XNo If Yes, Giva Year or Dates: 1 Never Married 287 Married 1 ☐ Yes 2 XNo Specity: **Black** 3 Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DD NDT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Private College (1-4or 5+) Domestic 11th 17. Fether's Nema (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Pernell Scott Brice, Sr. Ruth Mae Atkins 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Kenneth Davis 2848 Edgecomb Circle South, Balto, MD 21215 20e. Method of Disposition 20b. Place of Disposition (Neme of cematery, cremetory or other place) 20c. Location - City or Town, State 1 St Burial 2 ☐ Cremetion 3 ☐ Removel from State King Memorial Park 9/8/98 Randallstown, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility Unity Funeral Services @ Leroy0. Dyett 4600 Liberty Heights Ave., Balto., MD21207 23e. Pert1. Enter the disease, of complications that causad the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Onsat and Deeth RENAL. Immediate Ceuse (Finel diseese or condition resulting in death) AMYLOIDOSIS 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were eutopsy findings aveilable prior to completion of cause of deeth? 24a. Wes en autopsy 1 ☐ Yes 2 ☐ No 1 Yas 2 No

Physician /Medical Examiner

ding physician and

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certificate

To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p.

by 90

Completed

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Medical Certification: To

Box 68760,

Division of Vital Records, P.O.

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

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Completed

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7 is marked other than "natural", or items 23s or 28s-f shov traumetic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours effer to Department of Health and Mental Hydines. Important: if them 27 is marked other than "natural", or then any injury or other trauments.

Baltimore, Maryland 21215-0020

the Marylend

Physician/Medical Examiner Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Couse (Disease or injury that initiated events rasulting in death) Last

Pert II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I.

25. Was cese raferred to medical Hospitel: 1 Yes 2 No 1 ☑Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

27. Manner of Deeth 1 Neturel 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide

28a. Dete of Injury (Month, Day Year) 28b. Time of

ise of deeth (Item 23e) (Type, Print)

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury et Work? 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

1 Certifying Phyelcian: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner stated.

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29b. Signatura and titla of cart

29c. License number

29d. Date signed (Manth, Dev. Year)

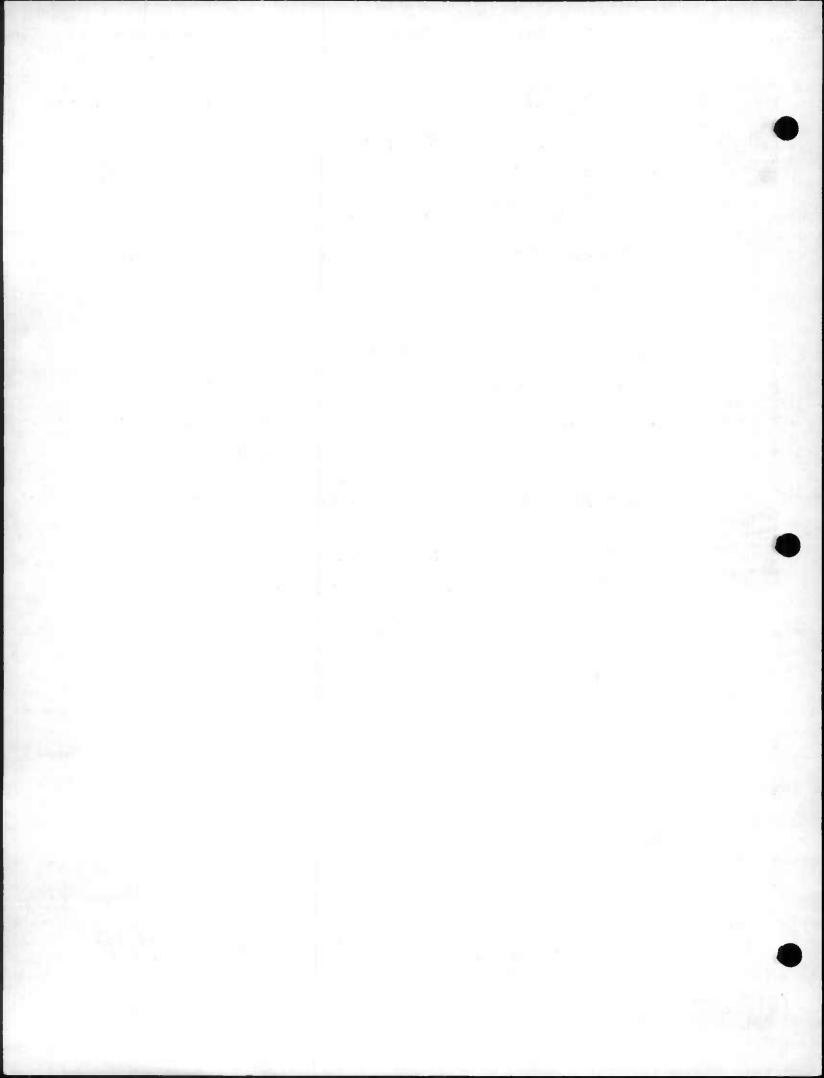
29e. Certifier

30. Name and

31. Date filed (Month, Day, Yeer) **SEP 0 8 1998**

22. Registrer's Signetura

State Registrar



Physician

/Medical

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Hospital or Attending Physicien:
 24 hours after death.
 Funerel Director: After this cartifical

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Division of Vital Records, P.O. Box 68760

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Physician/Medicai

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Certification:

Medical

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DWIN DAV	IS			State	oi iviar	yland /				Health and M Death		Reg. No.	3 2	7277	
		1. Decedent's Na	ame (First, Middle,	Last)							2. Date of De			3. Time of Death	
Phys /Me	ician dical				Edwi	in J.	Davi	S						7:32 AM	
Exam									4b. City, Town, or L BALTIM						
Funer Directo		5. Social Security 220-52-	6875	6. Sex XIXIM 2□ F	1	(In yrs. last	birthday) Yrs.	If Under Months	1 Year Deys	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, De July 22		9. Bird	thplace (State or Foreign to, MD	
D		Usual Residence													
the Marylan 28a-f ehow	tor	Md Md	10b. County N/A		1	10c. City, To B o	own or Lo							10d. Inside City Limits	
the	or 28s-f ellor or Director	10e. Street and Number 1228 Dellwood Avenue					10f. Zip Coda				10g. Citizen of What Country?			ountry?	
h with							21211					U.S.A.			
1215-0020 within 72 hours after death with the Maryland ana. It has "heturel", or items 23s or 28s-f show the Medical Examiner must be notified at	by Funeral							13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes XXXIV Specify:					14. Race - American Indien, Black, White, etc. Specify: White		
72 ho	eted	(Sp	15. Decedent's Education (Specify only highest grada completed)				16a. Decedent's Usual Oc (Give kind of work do life. DO NOT use re			petion during most of work	16b. Kind of Businass/Industry				
U DEF	Completed	Elementary/Se 12th	econdary (0-12)	College	(College (1-4or 5+)			ainen		ed)	Apartments				
be filed tal Hygi d other	Be	17. Father's Nam	na (First, Middle, L	ast)						18. Mother's Nam	ne (First, Middle	, Maiden Surn	ame)		
ylan buld be Mental mrked o	ToB	Henry	Davis				Elizat					beth			
C = 0 -			19a. Intormant's Name/Relationship (Type, Print) Pam McCarty (Daughter)					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3502 Buena Vista Avenue Balto, MD 21211							
Ore,		20a. Method of D		3 Removal trom		20b. Place ceme	of Dispo	sition (Name of the Memor	e of her pla	ice)	Date 9/4/98	20c. Location Sykesv	n - City or	Town, State	
Baltim permit. Par Departmen important: any injury	once.	21. Signature of	Fyreral Service	site	ut.		Bu	rgee-	Her	ess of Facility		21211			

21. Signal

That the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart tailure. List only one cause on each line. 21211

Approximate Interval Between Onset and Death

Immediata Causa (Final disease or condition resulting in death)

Arteriosclerotic Cardiovascular Disease

Dua to (or as a consequance ot):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaasa or injury that initiated events resulting in death) Last

Due to (or es e consequenca ot):

Due to (or es e consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

INSPECTION

24b. Wera autopsy tindings available prior to completion of cause of death? 1 Yas 2 No

1 ☐ Yes XX No

26. Placa of Daath (Chack only one)

25. Was case reterred to medical axaminer? XXYes 2 No 27. Mannar ot Daath

Hospital: 1 ☐ Inpatient XX ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) 5 Pending Investigation

28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Rasidenca 6 Other (Specify) 28d. Describe how injury occurred

28e. Placa of Injury - At home, tarm, street, tactory, office building, etc. (Specify)

28t. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1 Certifying Phyalci (Check only one)

Watural

2 Accident

3 Suicide

4 - Homicida

To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.

Control busis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29b. Signatura and titla o u

6 Could not be datermined

29c. License number O.C.M.E 29d. Date signed (Month, Day, Year) SEPT. 1, 1998

30. Name and address Dennis Chute M.D. d cause of death (Item 23s) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year) SEP 0 8 1998 32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) **Physician** E. Lucille Duvall 1998 August 31, 12:15 AM /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner A Facility Nems (if not institution, give street endr Nephew's home 704 Grand Valley Court Social Security Number Westminster Carroll County If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** 1 M 2 K F Yrs. 215-56-5583 76 August 10,1922 Director Maryland Usuel Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "naturel", or items 23s or 28s-f sho traumatic event, the Medical Examinations to shoull ad at 1√√Yes 2 No Maryland N/A Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1444 Medfield Avenue 21211 USA Funeral filed within 72 hours efter death Hygiene. 14. Race - American Indien. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 ☐ Yes 2XXX No If Yes, Give Yeer or Detes: NONever Married 2□ Married "naturel", or 1 ☐ Yes 200No Specify: white à 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) than . Elementery/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien. Important: If item 27 is marked other that any injury or other traumatic event, manage. N/A N/A 5 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Milton Duvall Eva Yokel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Relationship (Type, Print) 1444 Medfield Avenue Baltimore, Maryland 21211
of Disposition (Name of Date 20c. Location - City or Town, State Virginia Seal Sister 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) Date 20e. Method of Disposition 1 X Burial 2 Cremation 3 Removel from State 9/2/98 Woodlawn, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Lorraine Park Cemetery 21. Signature of Engeral Service Licentin 22. Name end Address of Facility Burgee-Henss Funeral Home, PA 3631 Falls Road Baltimore, Maryland 21211 23a. Pert1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** Ventricular Arrhythmon /Medical tmmediete Ceuse (Finel disease or condition resulting in death) **Examiner** Physician/Medical Examiner TE PER Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last ettending physician 6 for use as the burialcertificate be 4 Therescheni 88 requires that the deeth signed by the e 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i Records, P.O. 2 No 3 Probably 4 Unknown perfense 1 ☐ Yes by 24b. Were autopsy findings eveilable prior to 24e. Wes en eutopsy performed? Completed peen completion of cause of deeth? certificate hes 1 ☐ Yes 2 ☐ No Division of Vital Physicien: 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ZNO 0 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this funeral 28d. Describe how injury occurred 27. Manner of Death 28c. Injury et Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: After t or Attending Netural 2 Accident 5 Pending investigation 1 Yes 2 No death. efter death Director: 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) filled in by 4 | Homicide 24 hours e Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, end due to the cause(s) and menner es steted.

2 Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and menner stated. 29a. Certifier (Check only one) Medicai completely within 2 29c. License number 29d. Date signed (Month, Dey, Year) 0 ATTENDING My. 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

schrau,

32. Registrer's Signature

846 W 364 Smeet, Balk W/2/2,

State Registrar Savhan

SEP 0 8 1998

31. Date filed (Month, Dey, Year)

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Please Type or Print in Black Indeiible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death **Physician** Via An Calvin R. Ebelein /Medical 4c. County of Dea 4b. City, Town, or Location of Death 4a Facility Nema (If not institution, giva street and number) Examiner Look About Manor Nursing Center Westminster Carrol1 If Under 1 Yaar If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) 6 Sax **Funeral** XXM 2DF Months 86 Yrs. 216 03 0255 Director Feb. 28, 1912 Georgia Usuel Rasidance of Decedent 10a Stata 10b. Count 10c. City, Town or Location 10d. Insida City Limits Maryland **Baltimore** Owings Mills 1 Yas 200 No Director 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 4706 Painters Mill Rd. 21117 United States Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 220 No If Yas, Giva Yaar or Datas: 14. Race - American Indian. 11. Marital Status Was Decedant of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxicen, Puarto Ricen, atc.) Black, Whita, atc. 1 Never Married 2 Married 1 ☐ Yas 2X No Specify: White þ 30XWidowed 4 □ Divorced Completed 16a, Dacedant's Usuel Occupetion 16b. Kind of Business/Industry 15. Dacedant's Education (Giva kind of work dona during most of working lifa. DO NOT usa ratired) (Spacify only highast grada completed) Pages 1 and 2 should be filled within 7 ment of Health and Mental Hygiene. ant: If item 27 is marked other than "rury or other traumatic event, the Mau Elemantary/Secondary (0-12) College (1-4or 5+) Tool and Die Maker Factory 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fathar's Nama (First, Middla, Last) Be William Ebelein Anna (Unknown) 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Ronald L. Ebelein / Son 4706 Painters Mill Rd., Owings Mills, MD 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Data 1 Burial 2 Cramation 3 Ramoval from Stata permit. Page Department of Important: If any Injury or Green Mount Crematory 9/5/98 Baltimore, MD 4 ☐ Donetion 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Dr., Ba. 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. 8717 Green Pastures Dr., Baltimore, MD 21286 Approximeta Intarval Batwaan Onset and Deeth **Physician** /Medical Immediate Cause (Final diseasa or condition rasulting in daath) Examiner Dua to (or as e consequence of): Examiner Saquantielly list conditions, if any, leeding to immadiata ceusa. Entar Undarlying Causa (Disaasa or Injury that Initiated events resulting in daeth) Last Dua to (or as a consequence of): Physician/Medical Dua to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other pignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. DISCHE ARKINSON'S 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings availabla prior to complation of ceuse of daath? AZZHEIMERS DEMENTIA 24a. Was an autopsy Completed 1 Yas 2 No 1 Yas 2 No 25. Was cesa rafarred medicel axaminar? Be 26. Placa of Death (Check only ona) Othar: 4 Nursing Homa 5 Residence 6 Dother (Specify) 1 Yas 2 No 2 1 Inpatiant 2 ER/Outpatient 3 DOA 27. Manper of Death 28a. Date of injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of Certification: 28c. Injury at Work? 1 Natural 5 Panding 1 Yas 2 No invastigation 2 Accident 6 Could not be datarmined 3 ☐ Suicide 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicida 29e. Cartifies Medicai Certifying Physician: To the best of my knowledge, deeth occurred at the time, data and place, and due to the cause(s) and mannar as stated.

Box 68760. Division of Vital Records, P.O. or Attending To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Af

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State Registrar 31. Data filed (Month, Day, SEP 0 8 1998

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(Check only one) 29b. Signature

32. Registrar's Signatura

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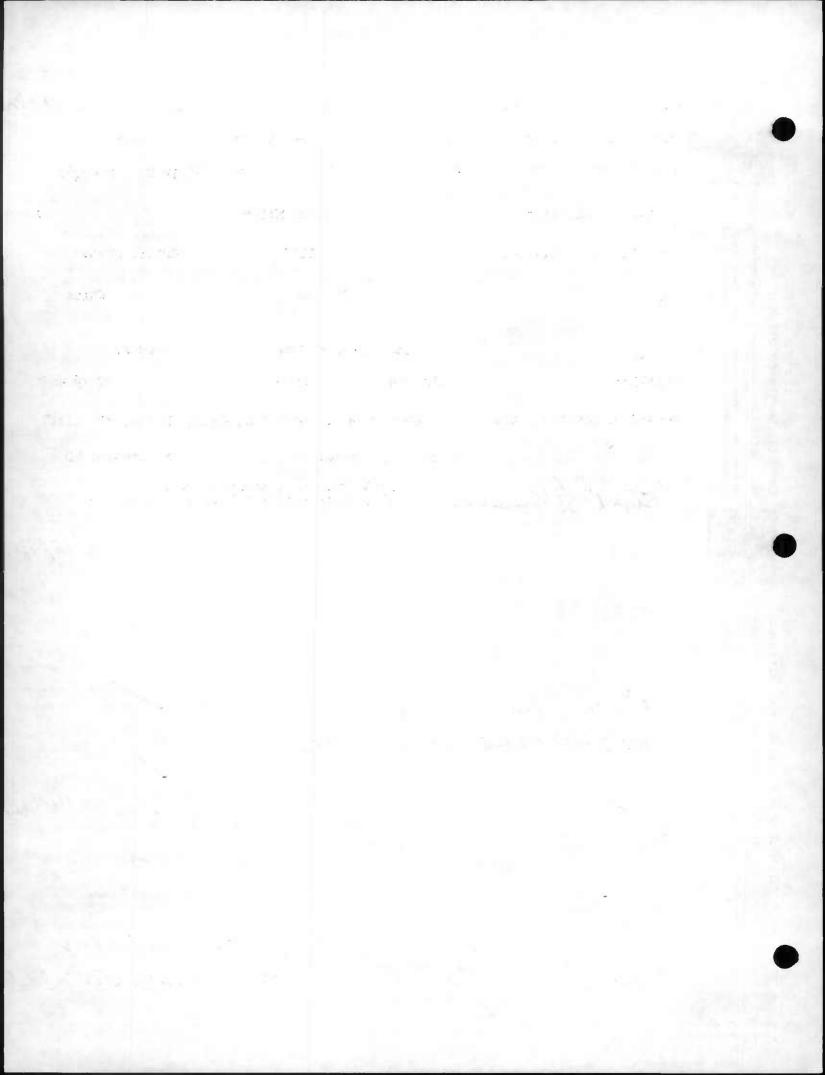
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2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, end due to the ceuse(s) and manner stated.

29c. Licansa number

29d. Data signed (Month, Day, Year)

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2 Date of Death 3 Time of Death Month **Physician** 4c. County of Deeth /Medical 4b. City, Town, or Location of Daeth 4a. Fecility Neme (If not institution, give street end number) Examiner Richey If Under 24 Hrs. 8. Da JOS-col HOSPICE 5. Social Security Number 215-34-57 18 If Under 1 Year 8. Date of Birth (Month, Dey, Yeer) 4-28-3 6. Sex 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□ M 25 F Months Days Hours Yrs. Director (7-A. Usuel Residence of Decedent death with the Marylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or itams 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at BARTIMORE Yas 2 No Director MID 10e. Street end Number 10f. Zip Coda 10g. Citizen of Whet Country? 3443 45A Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Dacedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Raca - American Indien, Black, White, etc. 11. Marital Status permit. Peges 1 and 2 should be filed within 72 hours efter a Department of Heelth and Mentel Hygiene. Important: If Nem 27 is marked other than "natural, or fam any injury or other traumatic event, the Medical English 1 Never Merried 2 Married 1 ☐ Yes 2 ☐ Mo If Yes, Give Year or Detes: Baltimore, Maryland 21215-0020 1□ Yes 2□No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education for only highest grede completed) 16e. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) Provider NA Nurse 17, Fether's Neme (First, Middle, Last), 18. Mothar's Name (First, Middle, Maiden Sumeme) Be a Ter SON Kobersan 2 Decta 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 2726 Mary 12N Cur. Baltimer, M. 21218 2 20b. Placa of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata Bunal 2 Crametion 3 Removel from Steta Sta 4 ☐ Donation 5 ☐ Other (Spacify) restem 21. Signatura of Funerel Service Licansee 22. Name end Address of Fecility 23e, l'ert1. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dylng, such es cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on each lina. SI MON, ME Physician Sunall Bower /Medical Immediate Ceuse (Finel 18 mos disease or condition resulting in deeth) Examiner Due to (or es e consequenca of) Examiner physician and s the buriel-trans Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury thet initieted events resulting In deeth) Lest Due to (or es e consequence of): of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of): ettending p 80 ed by the e Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Toknown ģ 24b. Were eutopsy findings aveileble prior to completion of cause of deeth? 24e. Wes en eutopsy parformed? Completed peen s certificate hes 1 Yes 2 No 1 Yes 2 No funeral director, 25. Wes case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpetient 3 | DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Dother (Specify) Hoghice Certification: To this 28e. Date of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of To the Hosp(a) or attending Pl within 24 hours after death. To the Funeral Director, After th completely filled in by the funera After Division 1 Naturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28e. Placa of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Suicida 4 | Homicide 29a. Certifiar (Check only one) 1 🗹 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted. Medical 2 Medical Exeminer: On the bests of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, date end piece, end due to the ceuse(s) end manner stated.

29d. Date signed (Month, Day, Yeer)

Taw St. By bo Med 21828.

State Registrar 29b. Signatura and title of certifier

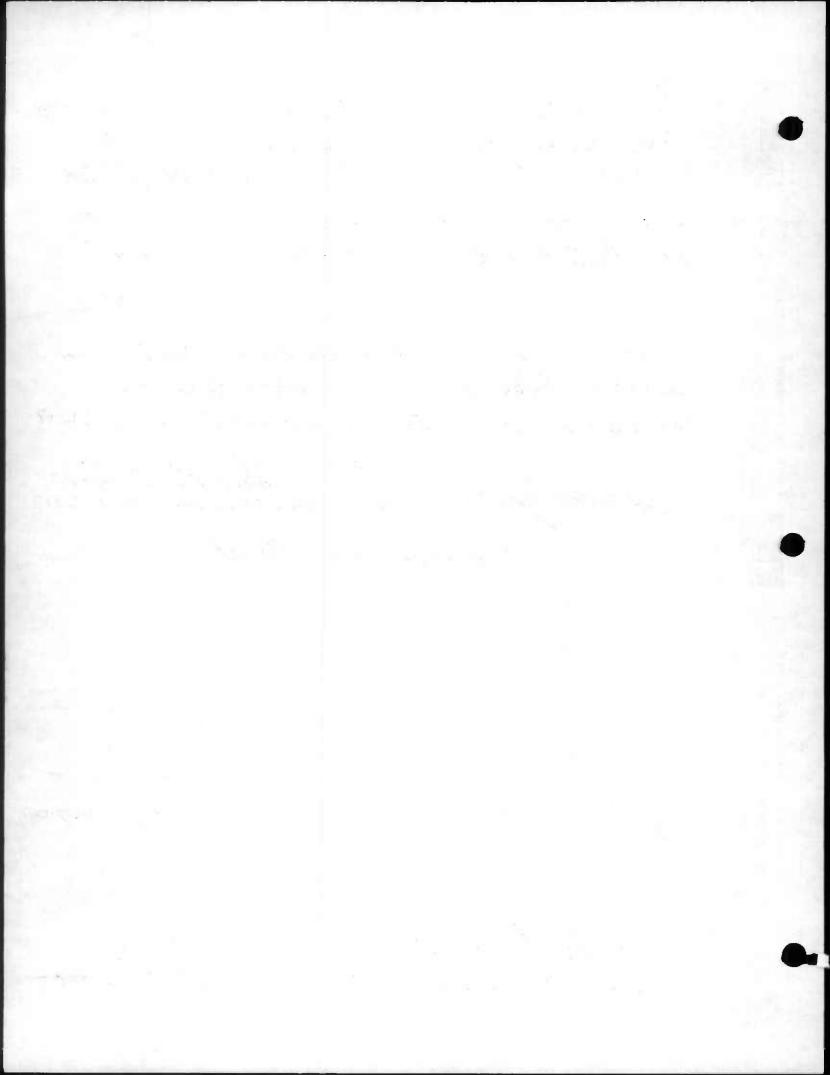
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30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

SEP 0 8 1998

32. Registrar's Signetura

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State of Maryland / Department of Health and Mental Hygiene 2728

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DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene

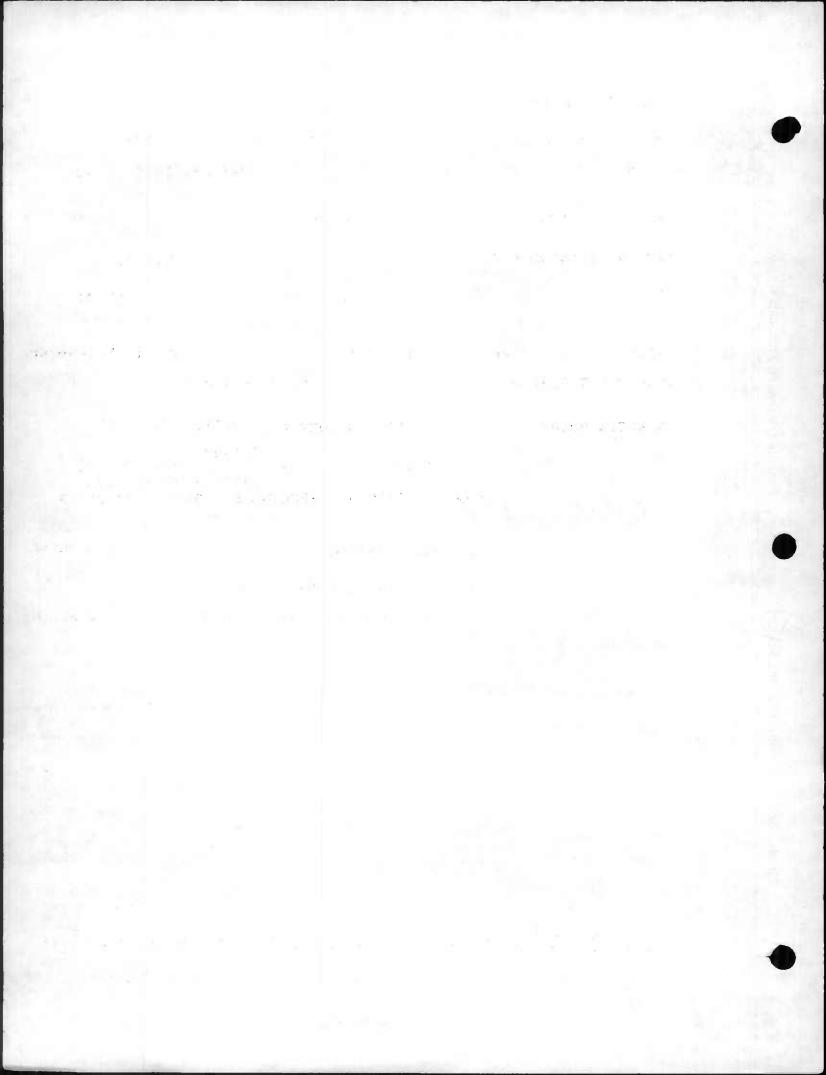
Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth SEPT, 1998 Year Day **Physician** 4, 0735 AM Jerry Arlington Franklin /Medical 4c. County of Deeth
BALTIMORE 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give straet end number)
7807 WISE AVENUE - REAR YARD **Examiner** DUNDALK If Under 1 Year | If Under 24 Hrs. B. Date of Birth Month Day, Yeard NOV 1, 1947 Birthplece (State or Foreign Country) 6. Sex 5. Social Security Number 7. Age (In yrs. last birthdey) **Funeral** Months Deys Hours ▼ M 2 F 413-74-7086 50 Yrs. Tennessee Director Usuel Residence of Decedent with the Meryland 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or itams 23a or 28a-f show 1 ☐ Yes 2 ☐ No Director MD Baltimore Dundalk 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 2600 Gray Manor Terrace 21222 USA permit. Pages 1 and 2 should be filed within 72 hours aftar death v Department of Haalth and Mentel Hygiene. Important: If Item 27 is marked other than "natural", or itama 23a anal hijury or other traumatic event, the Medical Examinet must abouts. Funeral 12. Was Decadent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Yeer or Dates: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indian, 11. Marital Stetus Bleck, White, etc. 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 No Specify: altimore, Maryland 21215-0020 Specify: White 3 Widowed 4 Divorced à Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 11 Handyman Miscellaneous Jobs 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Homer Arlington Franklin Nettie Reva Norris 0 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Edith Ann Smiddy/sister 2600 Gray Manor Terrace Dundalk, MD 21222 20b. Place of Disposition (Neme of cemetery, crematory or other pleca) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Burial 2 Cremetion 3 ☐ Removal from State Metro Crematory, Inc, 9/8/98 Baltimore, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Sewice Licensee MC 22. Name and Address of Fecility
Cremation Society of Maryland, Inc. Honald 299 Frederick Rd. Baltimore, MD 21228 Approximete Interval Between Onset and Deeth 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. **Physician** ordiouscular Disease /Medical Immediate Cause (Finel diseese or condition resulting in death) Examiner Due to (or as a consequence of) Examiner be executed ician and burlal-trans Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of): Box-68760 edical Due to (or es e consequenca of) 96 Physician/M Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? The law requires the 1 Yes 2 No 3 Probably Unknown Division of Vital Records, P. signed b by 24b. Were eutopsy findings available prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed ordusions, remote ils certificata hes I director, paga 2 1 Yes 2 No Yes 2□ No or Attending Physician: 25. Wes case referred to medical 26. Piece of Deeth (Check only one) Be Other: 4 Nursing Home 5 Residence MOther (Specify) AT SCENE XXYes 2 No 2 1 | Inpatient 2 | ER/Outpatient 3 | DOA this 28a. Dete of Injury (Month, Dey Year) funerel 28c. Injury et Work? 28d. Describe how injury occurred Certification: 27. Manner of Deeth 28b. Time of After 1 Naturel 2 Accident Injury 5 Pending 1 Yes 2 No death. investigation Director: A 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) in 24 hour. the Funeral Directory 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner es steted.

XXMedical Examiner: On the best of exeminetion end/or investigation, in my opinion, deeth occurred et the time, dete end pleca, and due to the cause(s) and menner steted. 29e. Certif edical completely To the within 2 O.C.M.E 29d. Dete signed (Month, Day, Year) SEPT. 5, 1998 eddress of person who completed cause of deeth (Item 23e) (Type, Print) -LARON LOCKE MD 111 Penn Street, Baltimore, Maryland 21201 31. Dete filed (Month, Day, Year) SEP 0 8 1998 32. Registrar's Signeture State renew Registrar

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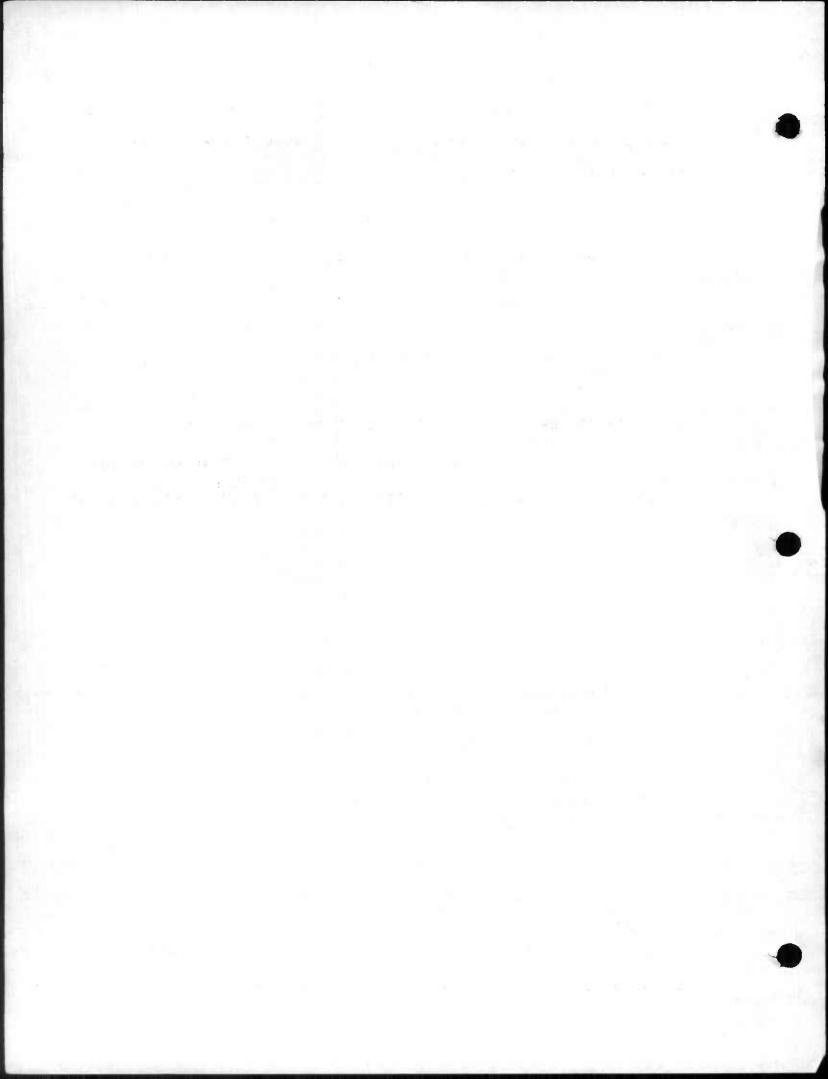
State of Maryland / Department of Health and Mental Hygiene 8 27283

				Cen	tificate o	f Death			Reg. No.		
	1. Decedent's Name (First, Middle, La							2. Date of De Month		Year	3. Time of Deat
ysician Medical	AUDREY FI	126EFAC	.13					SEPTEN		Year 998	4:05 A
aminer	4a Facility Name (If not institution, giv SINAL HOSPIT	TAL				BAL	TIM		N/	Α	
eral ctor	5. Social Security Number 6. S 2 1 2 - 3 4 - 4 4 1 8	Sex 7. A 1□M 2√2 F	ige (In yrs. last b	Yrs.	If Under 1 Yes Months Day	ar If Under	Min.	8. Date of Bir (Month, De MAY 24	th ay, Year) 1, 1939	9. Birthp Coun	lace (State or Ford try) MD
	Usual Residence of Decadent 10a. State 10b. County		10c. City, Tox	wn or Loc	ation					1	0d. Inside City Lin
Director	MD N/	A	100. Oily, 101	WIT OF EOC	BAI	OT					NSWes 2□
Dire	10e. Street and Number				10f. Zip Code	•		1.	10g. Citizen of V	Vhat Cour	itry?
	1204 N. ELLWO			1		213			U.S.		an Indian.
Funeral	11. Marital Status	12. Was Decedent	?	13. Vi	las Decedent o Yes, specify C	uban, Mexica	in, Puerto	Rican, etc.)		k, White,	
by F	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 N If Yes, Give Year or Dates:	•	1	□Yes 2XN	lo Specify	:		Specify	BLA	CK
Completed	15. Decedent's En	ducation	166	a. Decede	ent's Usual Occ cind of work dor O NOT use ret	cupation	st of work	Ina	16b. Kind of Bu	usiness/Ind	dustry
nple	Elementery/Secondary (0-12)	College (1-4or	(5+)			ired)					
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To Be	17. Father's Neme (First, Middle, Last, ROBERT FITZGE:							E SCOT		16)	
	19a. Informant's Name/Reletionship (Type, Print)	19	b. Mailing	g Address (Stre	et and Numb	er or Run	al Route Numb	per, City or Town,	State, Zip	Code)
	PATRICIA MOOR	E			PEMBR		VE	BALTO	MD 2		
	20a. Method of Disposition 1 ★ urial 2 □ Cremation 3 □	Removal from State	cemen	ery, crem	atory or other p	olace)	9.	-9-98			
	4 Donetion 5 Other (Specif	-	Ba	-	mork		cm-		Bal-		
	21. Signature of Furieral Servica Licer	nsee			Name and Add		, B.		UNERAL		
	Patricia	450	llo	- 1	29 N.				BALTO,	MD 2	
Г	23a. Part . Enter the disease, or com shock, or heart failure. List only	one cause on each	line.	not ente	r the mode of c	lying, such as	s cardiac	or respiratory a	arrest,	- 1	Approximate Interval Between Onset end Death
Į,	Immediate Ceuse (Final		LIVER	FA	ILURE	_					1 YEAR
	disease or condition resulting in death)	a	Due to (or es							- 1	
je			CARCI			IOR					1 YEAR
Examiner	Sequentially list conditions,	b	Due to (or as a	CONSEGR	uence of):					1	1
edical Ex	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last	C	RESTA Due to (or as a		VE CA	PDIOI	MYOF	PATHY		1	6 MONTH
2		d									
Sick	Part II. Other algolificant conditions of	contributing to death	but not resulting	In the un	derlying cause	given in Part	1.	23b. Dld	I tobacco use co	ntributa t	o the cause of de
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Completed by P								24a. Was	s an autopsy ormed?	av	ere autopsy tindin vailable prior to empletion of cause deeth?
mpl											/
င္ပ	OF Man and referred to medical					00 51-	45		Yes 2 No	11	☐ Yes 2☐ No
o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	tlent 2 ER/C	Outpation	3□ DOA	Other:		th (Check only	one) sidence 6 □Oth	er (Sneci	6/1
-	27. Manner of Death	28a. Date of In	iury 28b	. Time of		njury at Vork?	diang in		how injury occur		77
cation	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b			Injury	M 1	Yes 2]No	006 1	(Ch 1 1 2 1 1	har as Bus	of Doute Number
Certification:	4 Homicide determined	289. Placa of II	njury - At home, etc. (Specify)	tarm, stre	et, factory, offi	C&			(Street and Numi own, State)	oer or mun	ar ribute ryumber,
edical	29a. Cartifier (Check only one) 1 ☐ Certifying Pt 2 ☐ Medical Example 1 ☐ Certifying Pt (Check only one)	nysician: To the bes miner: On the basis and manners	of examination a	ge, death and/or inv	occurred at the estigation, in m	time, date a y opinion, de	nd place, ath occur	and due to the red at the time	cause(s) and m , date and place,	enner as s and due t	stated. o the cause(s)
×	29b. Signature and title of certifier D (les, M	, D.			ense number 2402		DT9920	29d. Date signe SEPTEM		Day, Year)
	30. Name and address of person who				Print)	TAI	GR	EENSP	PING AL	IENU	E
04-1		-	trar's Signatura				, , ,				
	18 1998	5 Hegis	A. J. Signature	9	las .						
State gistrar		completed cause of	death (Item 23a	JAI		TAL,			RNG AL		-



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Date of Death Month **Physician** BESSIE SEPTEMBER 1631 FORT /Medical 4a. Facility Nama (If not Institution, giva street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner BALTIMORE HOME AND HOSPITAL CHURCH If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Months Deys Hours Min. (Month, Day, Year) 5. Sociei Security Nymber 7. Age (In yrs. last birthday) Birthplace (Stata or Foreign Country) **Funeral** 1 M 200 F Months 226 32 5841 Yrs. 1942,192 Director Usuai Rasidance of Decedent with the Maryland 10e. State 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Modical Examinat must be notified at 1 X Yas 2 □ No Director MD N/A BALTO 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 1027 CATHEDRAL ST 6F U.S.A 21202 pemit. Peges 1 and 2 should be filed within 72 hours after death 1 Department of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s any injury or other traumatic event, the Mode Funeral 12. Wes Decedant Evar in U,S. Armed Forces? 14. Rece - Amarican Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Ricen, atc.) 11. Meritei Stetus 1 ☐ Yes 27 ☐ No If Yas, Giva Yaer or Dates: 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2√☐No þ Specify: BLACK 3℃Vidowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Eiementary/Secondary (0-12) College (1-4or 5+) 9th N/A FOOD SERVICE SCHOOL SYSTEM 17. Fether's Neme (First, Middla, Last) 18. Mother's Name (First, Middle, Maidan Sumama) Be GEORGE HURT SR 2 VIRGINA MOLTEN 19e. Informent's Name/Raiationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) ERNESTIA KESLER 2233 AISQUITH ST BALTO, MD 21218 20b. Place of Disposition (Nama of cemetery, crametory or other place) 20e. Mathod of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriei 2 ☐ Cramation 3 ☐ Removei from State 4 ☐ Donatiop 5 ☐ Othar (Specify) BALTIMORE CEM 9-10-98 BALTO, MD 22. Neme end Address of Fecliity BETTS FUNERAL HOME 21. Signature of Funarai Service Licenses 1129 N. CAROLINE ST BALTO, MD 21213 Vuca 23a. Part1. Entar the disease, or complications that eaused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** immediata Causa (Final disease or condition rasulting in death) /Medical PANCYTOPENIA Examiner Due to (or as a consequance of): Examiner YEAR MYELDMA MULTIPLE burial-transit be executed Sequentially list conditions, if any, laading to immediata cause. Entar Undarlying Cause (Disease or injury that initiated evants rasulting in death) Last Dua to (or as a consequence ot): and siclan Physician/Medicai Dua to (or as a consequance of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? Records, P.O. ê signed by d be detect 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown MYOCARDIAL INFARCTION þ 24b. Wara autopsy findings evellable prior to completion of ceuse of death? 24a. Was an eutopsy performed? Completed RENAL FAILURE this certificate 1 ☐ Yas 2 NO 1 ☐ Yas 2 ☐ No Division of Vital 25. Wes cesa ratarred to medicei axaminar? Be 28. Piace ot Death (Check only ona) Hospitai: 1 Pinpatient Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 2 1 Yas 2 No 2 ER/Outpatient 3 DOA in by the funeral 27. Manner of Death 28a. Data of injury (Month, Day Year) After t 28b. Tima of 28c. injury at Work? 28d. Dascribe how Injury occurred 1 Naturai 5 Pending Invastigation death. 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi 2 Accidant 6 Could not be determined 3 ☐ Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) Piace of injury - At homa, tarm, street, factory, office building, atc. (Specify) 4 Homleida 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and menner stated. 29a. Cartifier Medical (Check only one) 29b. Signature and fille of certific 29c. Licansa number 29d. Date signed (Month, Dey, Year) MD 39629 SEPTEMBER 30. Nama and distinues of person who completed ceusa ot death (item 23a) (Typa, Print) 4LGX ANDER MD BAUIMORE MD CHURCH HOME AND HOSPITAL 31. Data filed (Mooth, Day, Year 32 Ragistrar's Signatura State Registrar



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Tima of Deeth 1. Decedent's Nama (First, Middle, Last) 2. Dete of Deeth Yeer 98 Month **Physician** DOROTITY RANKLIN 2110 0 /Medical 4a Facility Name (If not institution, giva streat and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner MMS N/A 5. Sociel Sacurity Number 6. Sex If Undar 1 Y 8. Dete of Birth (Month, Dey, Year) 07/22/1,928 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** Months Deys Hours Min 1 M 2 DEF 217-26-2649 Yrs. 70 Maryland Director Usual Residence of Decedent with the Meryland 10e Stete 10h County 10c. City. Town or Location 10d. Inside City Limits Pages 1 end 2 should be filed within 72 hours efter death with the Merylan nent of Health and Mental Hyglene. Int: If item 27 is marked other than "naturel", or items 23s or 28s-f show ary or other traumatic event, the Wedical Examener must be notified at MD N/A Baltimore 1 XYes 2 No Director 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 21213 U.S.A. 3629 Lyndale Avenue Funeral Race - American Indien, Bleck, White, etc. Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 11. Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Giva Yaer or Detes: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black þ 3 Widowad 4 Divorced Completed 18a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grede completed) Mercy Hospital College (1-4or 5+) Elementery/Secondary (0-12) Food Handler 9th 18. Mother's Neme (First, Middle, Meiden Sumama) 17. Fethar's Nama (First, Middla, Last) Alfred Robinson Iantha West 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) Evelyn G. Curry 9326 Vollmerhausen Rd., Savage, MD 20763 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Steta 1 ₺ Burial 2 □ Cramation 3 □ Ramovel from Stete permit. Page Department of Important: If any Injury or King Memorial Park 9/9/98 Randallstown, MD 4 ☐ Donetion 5 ☐ Othar (Specify) 22. Name end Address of Fecility
LEROY O. DYETT & SON FUNERAL HOME, P.A. 21. Signetur of Funeral Service License 4600 LIBERTY HEIGHTS AVE., BALTO., MD21207 diseas v or complications that caused an initiate int only one ceuse on each in the deeth. Do not enter the mode of dylng, such es cardiac or respiratory errest, Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Finel Aneury horacic disaase or condition resulting in death) Examiner Due to (or es e consequence of): Examine Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting In deeth) Lest Due to (or es e consequence of): and Physician/Medical Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 TUnknown signed to þ 24b. Were eutopsy findings eveileble prior to complation of causa of deeth? Completed 24a. Was an eutopsy page 2 1 Yes 2 No 2 PNO 1 TYes certificate or Attending Physician: director. 25. Wes cese referred to medical 26. Place of Deeth (Check only one) axemine! Othar: 4 Nursing Home 5 Rasidence 6 Other (Specify) 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Menne of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 28e. Dete of Injury (Month, Dey Year) 1 Neturel 5 Pending efter death. 1 ☐ Yas 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28t. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 24 hours e Hospital 1 A Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier edical To the Hosp within 24 ho To the Fune completely f (Check only one) 29d. Data signed (Month, Dey, Year) 29c. License number 29b. Signety and title of certifier 30. Name and eddress of person who completed cause of deeth (It 1) 3ay (Type, Print) University of Murpland Whye Jr. 32! Registrer's Signeture riest

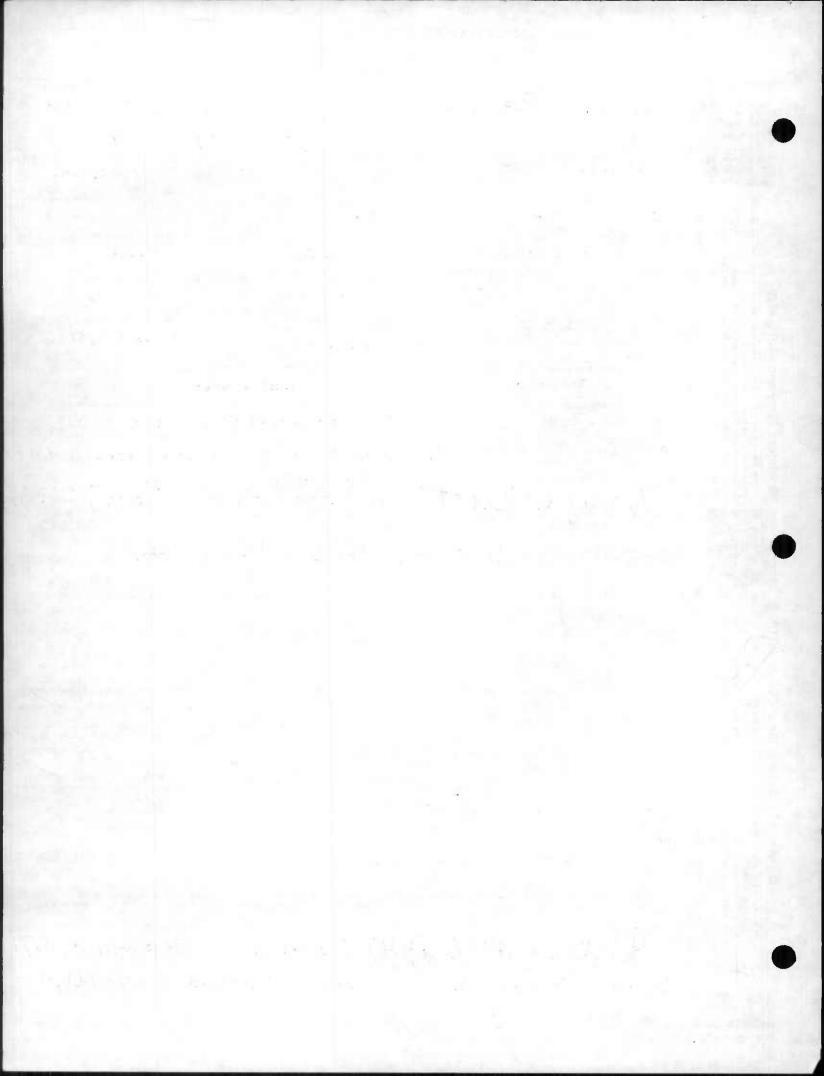
DHMH 16 Rev 6/95

State

Registrar

31. Dete filed (Month, Dey, Year)

SEP 0 8 1998



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year VERNON C. FANGMAN, SR. AUGUST 27, 1998 4c. County of Death 11:55 PM 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death Saint Joseph Medical Center Towson Baltimore If Under 24 Hrs. Hours Min. 5 Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1MM 2□ F Months 214-18-6776 NOV. 7, 1921 MARYLAND Usual Residence of Deceden 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yas 2 No MARYLAND JARRETTSVILLE: 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 14. Race - American Indian, Black, White, etc. 3956 RUSH ROAD 21084 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2KMarried 1 ☐ Yes 2 ☑ No Specify: WWII WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 YEARS BGE SERVICE MAN 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) CHARLES FANGMAN BERTHA GEYER 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LAURA A FANCMAN 20a. Method of Disposition 20b. Place of Disposition (Name of cometery, crematory or other place) 3956 RUSH ROAD JARRETTSVILLE, MF 21084 20c. Location - City or Town, Stete 1 ☐ Buriel 2 Cramation 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE WASHINGTON CREMATORY, INC. LAUREL, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility WITZKE FUNERAL HOME OF CATONSVILLE, INC. 1638 EDMONDSON AVENUE CATONSVILLE, MD 2000 21228 234 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shown or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death METASTATIC ADENOCARCINOMA UNKNOWN PRIMARY Immediate Cause (Final 6 MONTHS disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or injury that initiated week! Due to (or as a consequence of): that initieted events rasulting in death) Last Dua to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes 1 Yes 2 No 26. Place of Death (Check only one)

Physician /Medical Examine

Physician

/Medical

Examiner

10a. State

Funeral

Director

notified at

8 23a

"natural", or

Hyglens.

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Jamil. Pages 1 and 2 should to Department of Health and Ment mportant. If them 27 is marked

Maryland 21215-0020

altimore.

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Funeral

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Physician/Medical ģ Completed 88 2 Certification:

death. ij 8 e Funeral Dietaly filled

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Within 2 To the P

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25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Natural 5 Pending

2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 4 ☐ Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and title of certifier melle

D41410

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) August 28

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOGINDER P. MEHTA M. D., 7620 YORK ROAD, TOWSON, MARYLAND 21204

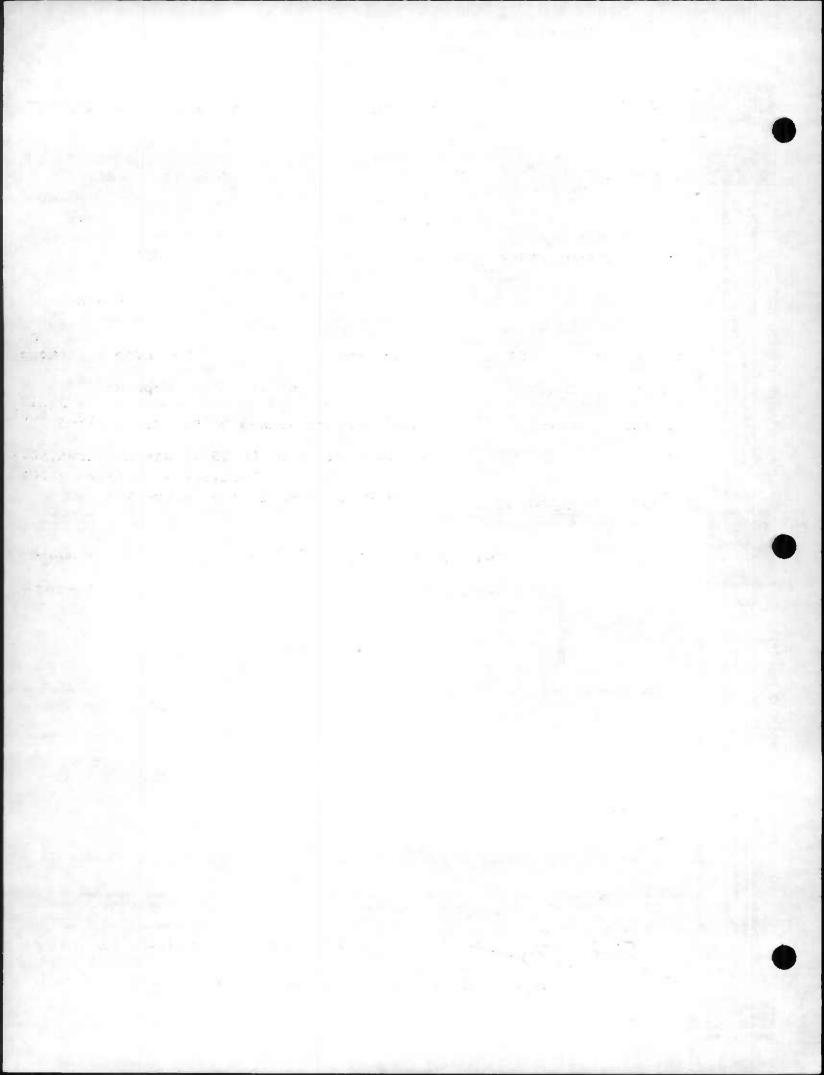
31. Date filed (Month, Dey, Year) SEP 0 8 1998 State Registrar

29a. Certifier (Check only one)

32/Registrar's Signature

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 98 27287

					OCILIII	ivale u	of Death		He	eg. No.		
	1. Decedent's N	ame (First, Middla, La:	st)					2.	Date of Deat Month		Yaer	3. Time of Death
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aminer	4a Facility Nam	a (If not institution, give	a streat and number)			,	4b. City, To		tion of Death		fy of Death	
	Unive	ersity of	Maryland	Hos	pital		Balti	more	City	N	Λ	
	5. Social Securit	y Number 6. S		(In yrs. las	t birthday) If	Under 1 Ye		24 Hrs. 8. Min.	Date of Birth (Month, Day,			place (Stata or Foraig
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Funeral Director	11. Marital Statu		12. Was Decedent E Armed Forces?			Decedent o	of Hispanic Original	gin? (Specif	y Yas or No-		ace - Amaric	
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	21. Signature of	Funeral Service Licen	1500		22. Na	ame and Ad	Idress of Facilit	у Ва.	It1mo	re, M	aryıa	and 2120
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dey September 4, 1998 Frances Gross 12:43 pm 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth 1528 Putty Hill Avenue Baltimore Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) July 25, 1924 Maryland 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthdey) Birthplece (Stete or Foreign Country) Months Days Hours Min 1 M 2 F 74 Yrs. 219-18-6755 Usuel Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Baltimore **Baltimore** 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1528 Putty Hill Avenue 21286 United States 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Raca - American Indien, Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorcad 16e. Decadent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 17. Fether's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumeme) George Sewell Margaret Stern 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Relationship (Type, Print) Mr. Eugene J. Gross / Husband 1528 Putty Hill Avenue Balto., MD 21286 20b. Pleca of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1X Buriel 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) MSVC-Garrison Forest 9/8/98 Owings Mills, Maryland 22. Name end Address of Fecility Leonard J. Ruck, Inc. Funeral Home 21. Signature of Funeral Servica Licensee wy 5305 Harford Road Baltimore, MD 21214 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death Due to (or as e consequence of) Due to (or es e consequenca of): Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

Physician

/Medical

Examiner

Directo

Funeral

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Completed

Be

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Funeral

Director

with the Marylend

permit. Peges 1 end 2 should be filed within 72 hours efter death with the Marylen Department of Health end Mentel Hygiene. Important: If item 27 is marked other than "naturel", or items 23s or 28s-f ahow with juyry or other fraumatic event, the Medical Examiner must be not required.

altimore, Maryland 21215-0020

ettending physician for use es the buria

The lew requires that the deeth certificate be exec signed by the e should t ils certificate hes t director, page 2 s or Attending Physician: this funeral After death. within 24 hours efter death

To the Funeral Director: ,
completely filled in by the Hospital

P.O. Box 68760,

Division of Vital Records,

To the To the To the

Immediate Ceuse (Final disease or condition resulting in death) Physician/Medical Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Lest Pert It. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Tes 2 No 3 Probably 4 Unknown g 24b. Were eutopsy findings eveilable prior to completion of cause of death? 24a. Wes en eutopsy Completed 25. Was case referred to medical examiner? 1 Yes 2 LNO 1 Tyes 2 No Be (26. Piece of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Pesidenca 6 Other (Specify) Lo 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred Certification: 27. Manner of Deeth 28b. Time of 5 Pending Iniun 1 Naturel 1 Yes 2 No investigation 2 Accident 3 ☐ Suicide 6 Could not be determined 281. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier 1 Certifying Phyelcien: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the cause(s) end menner es steted (Check only one) 2 Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, death occurred et the time, dete end piece, end due to the ceuse(s) and menner steted.

Albert DeLoskey, M.D. 515 Fairmount Avenue 31. Dete fited (Month, Day, Year) SEP 0 8 1998

29b. Signature and to

32. Registrer's Signature

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

oaks

29c. License number

D23829

29d. Date signed (Month, Day, Year)

Suite 330 Towson, MD 21286

September 4, 1998

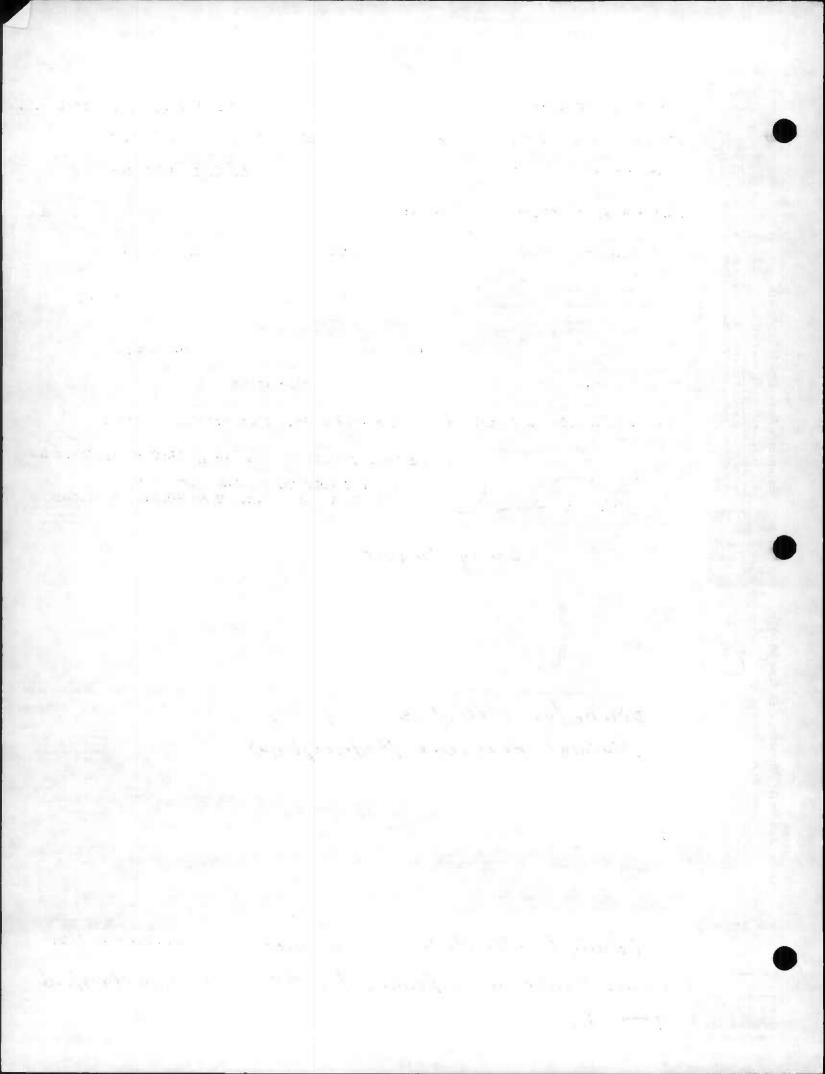
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5. Social Security Nu 212-22-51	imber 6. S		7. Age (In yrs. Id		If Under 1 Year Months Day			8. Data of Bir (Month, De	y, Year)	year) 9. Birthplace Country) 1926 Maryla	
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1 Never Marrie		Armed Fo 1 Yes If Yes, Giv Year or Da	rces? 2 1 No	It	Yes, specify Cu ☐ Yes 2 N	ban, Maxica	an, Puarto	Rican, atc.)		ck, White, e	otc.
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17. Father's Name (F					-111		her's Name		, Maiden Surnen	na)	7
		Turno Bright		10h 14-3'-	Address (Ct				or City or Tay	State 7:	Code
Philip W.			isband						er, City or Town, ie, MD 2		0000)
20a. Method of Dispo	osition		20b. PI	ace of Dispos	ition (Neme of letory or other p		1	Dete	20c. Location		wn, State
	Cremation 3 ☐ 5 ☐ Other (Specif		State		RK CEME			Sept. 1998	BALTIM	ORE,	MARYLAND
21. Signature of Futo	eral Service Licer	1500	J						OME, P.A		21061
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resulting in death) Lo	ast		eath but not resu	/		given in Pari	11.				the cause of death?
	orma/				Lxdroe	ceph	a/w	24a. Was	an autopsy ormed?	ava	re autopsy tindings illable prior to inpletion of causa death?
05 146	ed to see all to b							10		1 🗆	Yes 2□ No
25. Wes cese referre examiner?		Hospital:	npatient 2 1	B/Outnatien	3□ DOA			n <i>(Check</i> only o	on <i>e)</i> dence 6 □Oth	ner (Specify	<i>(</i>)
	5 Pending	28a. Dete d (Mont	of tnjury th, Dey Year)	28b. Time of Injury	28c. In				how Injury occur		/
3 ☐ Suicide 4 ☐ Homlcide	6 Could not b determined	e 28e. Plece building	of Injury - At hong, etc. (Specify	me, farm, stre	et, factory, offic	ө		28t. Location (City or To	Street and Numi wn, State)	ber or Rura	l Route Number,
	1 [™] Certifying Ph 2 Medical Exar		sis ot axaminati								
29a. Certifier (Check only one) 29b. Signature and t	vii C		, MIT		Do	nsa number	59		29d. Date signe SEPTEM		
30. Nama and addre	0 .	completed ceus	e of death (Item	23a) (Type, I	Print)	, A	ve.	Bala	fi more	Ma.	14/and
COLVI	" Curi	0,	(1-	()/ . [17/0	, ,,		10 1	4	,	11



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Daeth 3. Time of Death 2 199 F 4c. County of Death 4b. City, Town, or Location of Death 4e. Fecility Name (If not institution give street and number) BALTIMORE H Under 24 Hrs. Min. B. Date of Birth (Month, Day, Year) TUNE 7, 1961 RITCHIE HOSPICE 5. Social Security Number If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 218-76-8427 Usual Residence of Decedent 1□M 2×F Months Days Yrs. 10b County 10c. City, Town or Location 10d. Inside City Limits 1.X Yes 2 □ No MARULAND 10e. Street and Number og. Citizen of What Country? PLACE 2125/ 13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) USA. 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give 14. Race - American Indian, Black, White, etc. Never Married 2 Married 1 Yes 2 No Specify: 3 Widowed 4 Divorced If Yes, Give Year or Dates: BLACK 15. Decedent's Education (Specify only highest grada completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Ejementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER 10TH GRADE OWN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ELMER DELORES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 3095. GIL MORE A VENUE BALTIHORE, MO. 21223 ame of Date 20c. Location - City or Town, State MOTHER DELORES HALL 20b. Place of Disposition (Name of cematary, crematory or other place) 20a. Mathod of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State CEMETERV 9-9-98 LANGOOWNE, 4D. MT. ZION 4 ☐ Donation 5 ☐ Othar (Specify) To SERHE BROWN TR. FUNERAL Home states the death. Do not enter the mode of dying, such as cardiac or respiretory erfest, Approximate Approximate 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BROWN JR. FUNERAL Home Approximete Interval Between Onset and Death Immediata Causa (Final to the lung, brain disease or condition rasulting In death) Sequentially list conditions, if any, leading to immadiate causa. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 24b. Were autopsy findings eveileble prior to 24a. Was an eutopsy completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical 28. Place of Death (Chack only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Funeral

Director

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28a-f

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el Hyglene.

permit. Peges 1 and 2 should be file Department of Health and Mentel Hy Important: If Itam 27 Is marked other any Injury or other traumetic event

other traumatic event,

the Medical Examiner naut be notified at

Funeral Director

Be Completed by

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deeth with the Maryland

Peges 1 and 2 should be filed within 72 hours efter

21215-0020

Baltimore, Maryland

this certificete has director,

The law requires that the death certificete be executed

or Attanding Physician:

P.O. Box 68760,

of Vital Records,

þ Completed Be 2

filled in by the funeral After s efter death

To the Hospital o within 24 hours eff To the Funeral DI completely filled in

State Registrar

Medical

Physician/Medical Examiner Certification:

1 ☐ Yes 2 ☑ No 27. Manner of Death Natural 2 Accident

3 Suicide

29b. Signatura end title of certified

29a. Certifier (Check only one)

4 Homicide

6 Could not be

5 Panding Investigation

28a. Date of Injury (Month, Day Year)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 Yes 2 🗆 No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

Other: 4 | Nursing Home 5 | Residence 6 DOther (Specify) Hospic 2

112 Certifying Physician: To the best of my knowledga, daath occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 Madical Examiner: On the basis of axamination and/or investigation, in my opinion, daath occurred at the time, date and place, and due to the cause(s) and manner stated. Gayes um

29tt. License number

29d. Date signed (Month, Day, Year)

under 30. Name and addrass of person who completed causa of death (Item 23a) (Type, Print)

HAYES 40 6 Mic 31. Date filed (Month, Day, Yaar) 32, Registrar's Signature

SEP 0 8 1998

The French Committee The management of the first of

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Dete of Death 3. Time of Death Dey Month HORN 342 BARRY September 04 1998 4a Facility Neme (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death CITY JOHNS HOPKINS HOSPITAL BALTMORE If Undar 24 Hrs. If Undar 1 Yaar Birthplace (State or Foreign Country) 5. Social Sacurity Number 6. Sex 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Dey, Year) Months Devs Hours Min. 12 M 2□F 211-34-7988 Yrs. 54 3, May Pa. Usuet Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 No Pa. York Red Lion 10e Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? 1435 Windsor Rd 17356 USA 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☑ Yes 2 ☐ No If Yes, Give Yeer or Detes: Vietnam Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 11 Marital Status Bleck, White, etc. 1 Navar Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: 3 Widowed 4 Divorced White 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) Cotlege (1-4or 5+) 12 Plant Supervisor Manufacturing 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Rodger M. Horn Margaret Grove 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 1435 Windsor Rd. Red Lion, Pa. 17356 Mrs. Jane A. Horn/wife 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Susquehanna Mem. Gdns. 9/8/98 York, Pa. 21. Signature of Funeral Service bicense 22. Name and Address of Facility
Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 23a. Pert1. Enter the disease, or complications that causad the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximete Intervet Between Onset end Deeth Immediate Ceuse (Final PneumoniA 3 WEEKS diseese or condition resulting in deeth) Due to (or es e consequence of): Sequentially list conditions, if eny, leading to immadiate ceuse. Enter Undarlying Cause (Disease or injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): Dua to (or es a consequence of) 23b. Did tobacco use contribute to the cause of death? Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 1 Yee 2 No 3 Probably 4 Unknown FAILURY RENAL 24b. Were eutopsy findings availabla prior to completion of cause of death? 24a. Wes en autopsy UlcheATIVE ColitiS Synorome PARKINSON'S 1 Yes 2 □ No 1 Yes 2□ No 25. Was case referred to medical axeminer? 26. Plece of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yes 2 No 27. Menner of Death 1 Deleturel 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Panding 1 TYes 2 No 2 Accident 6 ☐ Could not be 3 Suicide Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

Examiner The law requires that the death certificate be executed Box 68760, Physician/Medical 98 for usa as Records, P.O. þ Completed Be Certification: To this funeral After deeth. the

3

Physician

/Medical

Examiner

Funeral

Director

than "natural", or items 23s or 28s-f show

lith end Mentel Hygiena. 27 Is marked other than "r r traumatic event, or Med

or other

Pages 1 and 2 should be I nent of Health and Mentel I int: If item 27 Is marked of

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Physician /Medical

Examiner

Director

Funeral

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Completed

Be

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filed withIn 72 hours after death with

21215-0020

Baltimore, Maryland

Division of Vital Attending Physician: 24 hours after deet Funeral Director: 6 filled in Hospital completaly within 2 To the

State Registrar

Medical

4 T Homicide

(Check only one)

29b. Signature and title of certifier

29a. Certifier

30. Nema end eddress of person who completed ceuse of death (Item 23e) (Type, Print) JEFFERSON 31. Data filed (Month, Dey, Year) 998

600 NORTH WOIFE STREET BALTIMERS 32 Registrer's Signeture

Tecrtifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) and manner as steted.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated.

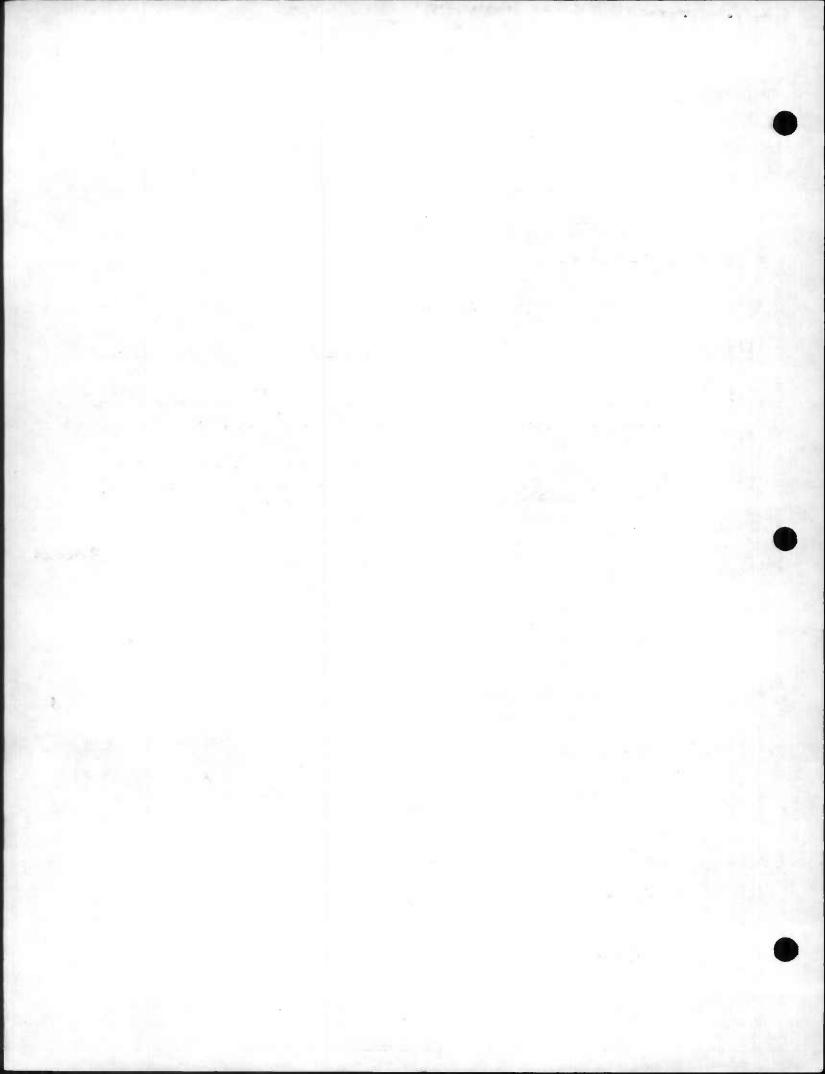
29c. License number

125-000

29d. Dete signed (Month, Day, Year)

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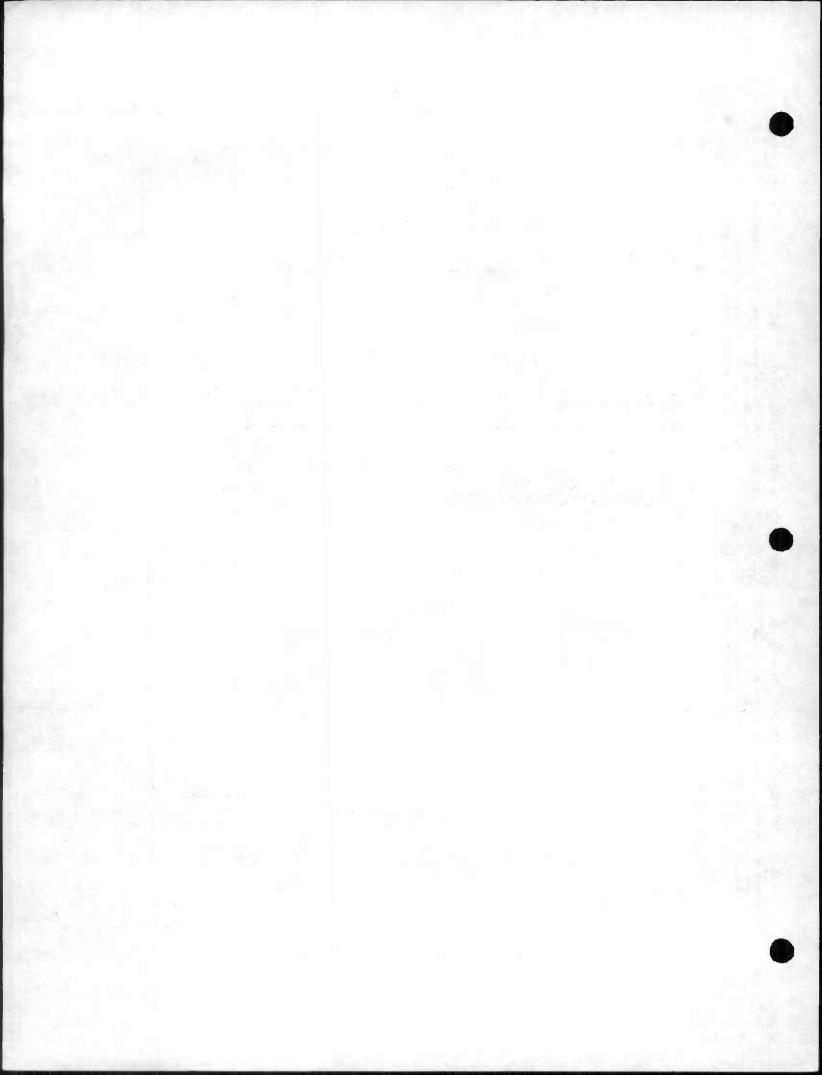
SEPTEMBER OH



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Data of Death 1. Decedent's Name (First, Middla, Last) 3. Tima of Death Day Month Year **Physician** HEDEMAN September 7, 1998 ROBERT 7:46 AM /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7313 Knollwood Rd. Baltimore If Under 24 Hrs If Under 1 Year 5. Social Security Number 8. Data of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** Days Months Hours 1XM 2DF Yrs. Nov. 1, 1945 Director 52 Md 213-44-8914 Usual Rasidence of Decedant with the Maryland 10b County 10c. City, Town or Location 10d Inside City Limits r than "natural", or items 23s or 28s-f show the Hedical Exponent must be notified at 1 ☐ Yes 2 No Director Md. Baltimore Towson 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code 7313 Knollwood Rd. 21286 TISA Funeral death Was Dacedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarlo Rican, atc.) 14. Race - American Indian, 11. Marital Status Black, Whita, atc. after 1 ☐ Yas 2 ☑ No If Yes, Give Yaar or Datas: 1 ☐ Never Married 2 ☐ Married Baitimore, Maryland 21215-0020 1 ☐ Yas 2 K No Specify: Specify. þ 3 ☐ Widowed 4 ☑ Divorced White Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grade completed) 16b. Kind of Businass/Industry Hygiene. Elemantary/Secondary (0-12) Collega (1-4or 5+) 12 5+ Attorney Self employed 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Itam 27 Is marked other any Injury or other traumatic avant pages. Be 0 William Norman Hedeman, Sr. C. Corson 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Mr. Harvey Greenberg/friend 2505 Ozark Cr. Baltimore, Md. 21209 20b. Place of Disposition (Nama of 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata cematary, crematory or other placa) 1 ☐ Burial 2 🗵 Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Hilltop Service Corp. 9/12/98 Towson, Md. a of Funeral Service Lic 22. Name and Addrass of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 23a. Part1. Entar tha disaasa, or complications that caused tha death. Do not antar tha mode of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only one cause on each line. Approximate Intarval Between Onset and Death **Physician** /Medical Immediata Causa (Final Month diseasa or condition rasulting in daath) Examiner Examiner Sequentially list conditions, if any, laading to immadiata cause. Entar Undarlying Cause (Disease or injury that initiated evants rasulting in death) Last Dua to (or as a consequenca of): physician and Box 68760 Physician/Medical the Due to (or as a consequanca of): for use as 189 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t 1□ Yes 2√ No 3 Probably 4 Unknown Records, by 24b. Wara autopsy findings available prior to Completed 24a. Was an autopsy performed? peen completion of cause of death? page 2 1 Yas 2 No 1 ☐ Yas 2 1 No certificate of Vital Attanding Physician: director, Be 25. Was casa rafarred to medical 26. Place of Death (Check only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 Yas 2 No edical Certification: To this 28a. Data of Injury (Month, Day Year) funeral 27. Mannar of Death 28b. Tima of 28d. Describe how injury occurred 28c. tnjury at Work? After Division 5 Panding invastigation 1 Natural A Birector: A in by It 1 Yas 2 No death. 2 Accidant 6 Could not be datarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida 6 within 24 hours aft To the Funeral Di completaly filled in Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Cartifier (Check only one) within 2 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifian 29c. License number 2 Permanen 30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print) Ka sel COOPER 09 evvi Sanel 31. Data filed (Month, Day, Year) 32. Registrar's Signature State SEP 0 8 1998 new Registrar soul



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month 9:05 AM Frances Katherine Hubbard 4, Sept. 1998 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Genesis Eldercare-Heritage Center Dundalk Baltimore 5. Sociei Security Number 7. Age (In yrs. lest birthday) If Under 1 Year if Under 24 Hrs. 8. Dete of Birth (Month, Dey, Yeer) 6. Sex Birthplece (State or Foreign Country) 1□M 2XF Months Deys Hours Min. 220-14-8127 Maryland March 8, 1907 Usual Residence of Decedent 10e Stete 10b Counts 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Maryland N/A Baltimore 10e. Street end Number 10f. Zip Code 10g, Citizen of Whet Country? 803 S. Dean St. 21224 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐XNo if Yes, Give Yeer or Dates: Wes Decedent of Hispenic Orlgin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American indien, 11. Maritel Status Black, White, etc. 1 ☐ Never Merried 2 ☐ Married 1 Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grade completed) Eiamantary/Secondary (0-12) Coilega (1-4or 5+) Homemaker Own Home 8th grade 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Thomas McComas League Mary 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Edward Hubbard 4419 Wynn Road, Baltimore, MD (son) 20b. Place of Disposition (Name of cemetery, crematory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Buriai 2 Crametion 3 Removal from Stete Oak Lawn Cemetery 9/8/98 Baltimore, Maryland 4 □ Denetion 5 □ Other (Specil 22. Name and Address of Fecility Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD of Funarel Service Lica 21. Signatur 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or haart failura. List only one cause on each lina. Approximata Intervel Between Onset end Deeth immediete Ceuse (Final diseasa or condition resulting in death) Sequentially list conditions, if eny, laeding to immediata cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Lest Due to (or es e consequence of) Pert ii. Other eignificant conditions contributing to death but not rasulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Whknown 24b. Were eutopsy findings eveileble prior to completion of cause of daeth? 24e. Wes en eutopsy performed' 1 Yes 20 No 2 1 No 1 Tyes 26. Piece of Death (Check only one) Hospital: 1 ☐ inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Rasidance 6 Other (Specify) 1 Yes 2 No 28e. Dete of injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. injury et Work? 1 Neturel 5 Panding 1 ☐ Yas 2 ☐ No investigation 2 Accident 6 ☐ Could not be datarminad 3 Sulcide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28a. Place of injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide

Examiner an and rief-transit Box 68760 edical Physician/M Division of Vital Records, P.O. à been signed t should be det by Completed page 2 s certificate Hospital or Attending Physician: funeral director, Be 10 After this Certification: efter death. filled in by 24 hours To the Hospi within 24 hou To the Funer completely fil edicai

Physician

/Medical

Examiner

Director

Funerai

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Completed

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Funeral

Director

7 is marked other than "natural", or itams 23a or 28a-f show traumatic event, the Medical Examinar must be notified at

permit. Peges 1 end 2 should be filed within 72 hours effer of Department of Health end Mentel Hygiene. Important: If Item 27 Is marked other than "natural", or than any injury or other traumatic event, the Medical Examination.

Physician /Medical

Examiner

Baltimore, Maryland 21215-0020

deeth with the Merylend

25. Wes case referred to medical axeminar? 27. Manner of Death

1 Certifying Physician: To the best of my knowledga, death occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated.
2 Medical Examinar: On the basis of axamination end/or investigetion, in my opinion, death occurred at the time, date end place, and dua to the causa(s) end menner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture and title of certifier

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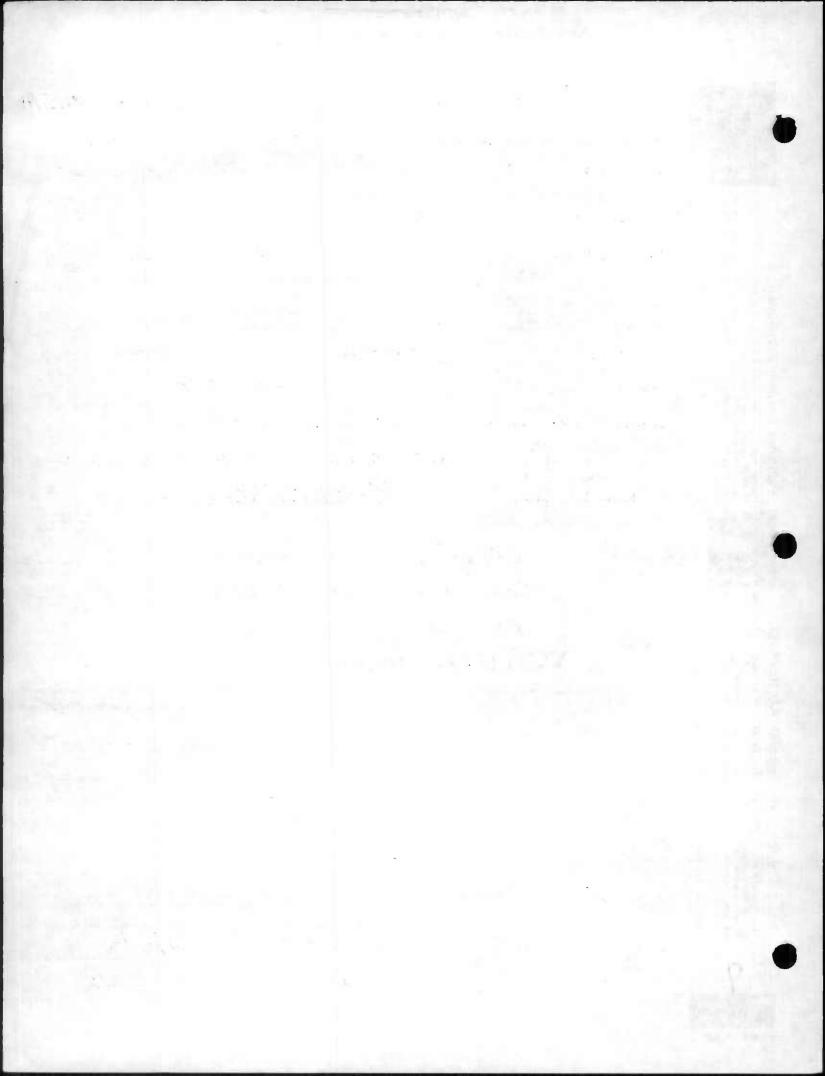
32. Registrer's Signeture

30. Name end eddress of person who completed cause of deeth (Itam 23e) (Type, Print)

Dunday MD

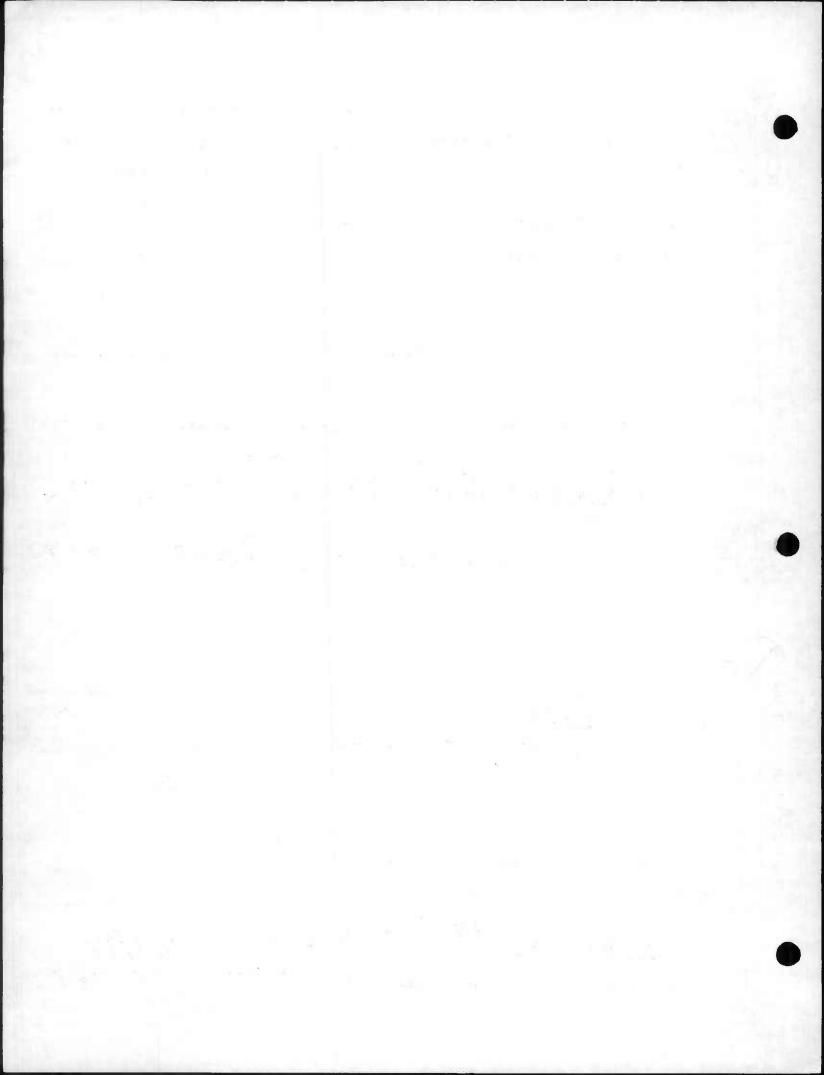
State Registrar arinder

31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			Certificate of	Death	Re	g. No.	61294
	1. Dacedent's Neme (First, Middle, Last)				2. Data of Deet	า	3. Time of Death
Physician /Medical	Edith	n Virginia H	i11		SEPT.	7. 1998	
Examiner	4a. Facility Name (If not institution, give st			4b. City, Town, or Lo		4c. County of D	
LAGITITION	Genesis Eldercar	e Catonsvil	le Commons	Cato	nsville	Bo 1	timore
Funeral	5. Sociel Sacurity Number 6. Sex	7. Age (In yrs. last	birthday) If Under 1 Yeer	If Under 24 Hrs.	8. Dete of Birth (Month, Dey,	The same of the sa	Birthplace (Stete or Foreign Country)
Director	216-20-2215 1 ¹	M 2∏F 87	Yrs. Months Days	Hours Min.	JULY 4,		country) aryland
land land	10e. Stete 10b. County	10c. City, T	own or Location				10d. Inside City Limits
Mary 4 sh	Maryland Baltimo		0 - 4 -	. 1 1		1 ☐ Yes 2 ☐ No	
ec los	10e. Street end Number	re	Catons 10f. Zip Code	Ville	4/	g. Citizen of Whet	Country?
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era era		2. Wes Decedent Ever in U,S.		1228		US	A merican Indian.
ler d		Armed Forces?	 Was Decadent of H If Yas, specify Cuba 	an, Mexican, Puerto	Rican, atc.)		hita, etc.
by		1 ☐ Yes 2 ☐ No It Yes, Give Yeer or Dates:	1 ☐ Yes 2 【XNo	Specify:		Specify:	White
ete	15. Decadent's Educa (Specify only highast grade	completed)	6e. Decadent's Usual Occup (Give kind of work done life. DO NOT use retired	etion during most of work d)	ing	6b. Kind of Busine	ss/Industry
withi within	Elementary/Secondary (0-12)	College (1-4or 5+)	Clerk			Coois1	Cooundton
	17. Fether's Nama (First, Middle, Last)		OICIK	18. Mother's Name	e (First, Middle, N		Security
Maryland 2 should be file th and Mental Hy 7 is marked othe traumatic event To Be (UNK.			UNK.	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,	
d Menider Marketic	19a. Informent's Neme/Relationship (Type	o Print)	9b. Mailing Address (Street		al Davida Alumbar	City on Town State	- Zin Code)
2 2 2 2 2							
te, Marylor 1 et al. Marylor 1 et al. Marke tem 27 is marke other traumatic	Joseph D. Serio/gr.	andson	602 S. Roll	ling Roa	d Cato	nsville	, MD 21228
or or or	1 ☐ Buriat 2 ☐ Cramation 3 ☐ Re	moval from State ceme	stery, crematory or other place	'		20c. Location - City	
dillinore, mit. Pages 1 er partment of Hea portant: If item y Injury or othe	4 □ Donation 5 □ Other (Specify)	Metr	o Crematory		9/8/98		more, MD
permit. Pages 1 and Department of Health Important: If item 27 any injury or other tronge.	21. Signeture of Funeral Service Licanses	The Omalo	22 Neme end Addre	ss of Facility On Socie derick R	ty of	Maryland	d, Inc. MD 21228
	23e. Part1. Enter the disease, or complice shock, or heart tailure. List only one	etions thet caused the death. E					Approximete Interval Between
Physician	shock, or heart tailure. List only one	ceuse on each line.					Interval Between Onset and Deeth
/Medical	Immediete Ceuse (Final	C 2 - 01	204 -11		V2000	0	7/4/
Examiner	disease or condition resulting in death) e.	along	ay wy	eny o	1)000	~	111
je je		Due to (or es	a consequence of)	0			
executed in end al-transit examiner	b.	Butter	, , ,				
Page I series	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury c.	Due to (or es	e consequence ot):				I
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tal or Attending P is effer death. al Director: Affer ted in by the funer. Certification:		Q (-p)/					
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral Medical Certification: 7	29a. Certifier 18 Certifying Physic (Check only one) 18 Certifying Physic 2 Medical Examine	clan: To the best of my knowled er: On the besis of examination end menner stated	ige, death occurred at the tin and/or investigation, in my o	ne, date end place, plnion, deeth occurr	and due to the ce ed at the time, da	use(s) end menner te end plece, end d	es stated. due to the cause(s)
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State Registrar	31. Dete filed (Month, Dey, Year) SEP 0 8 1998	32 Registrar's Signetura	G. Sour	,			

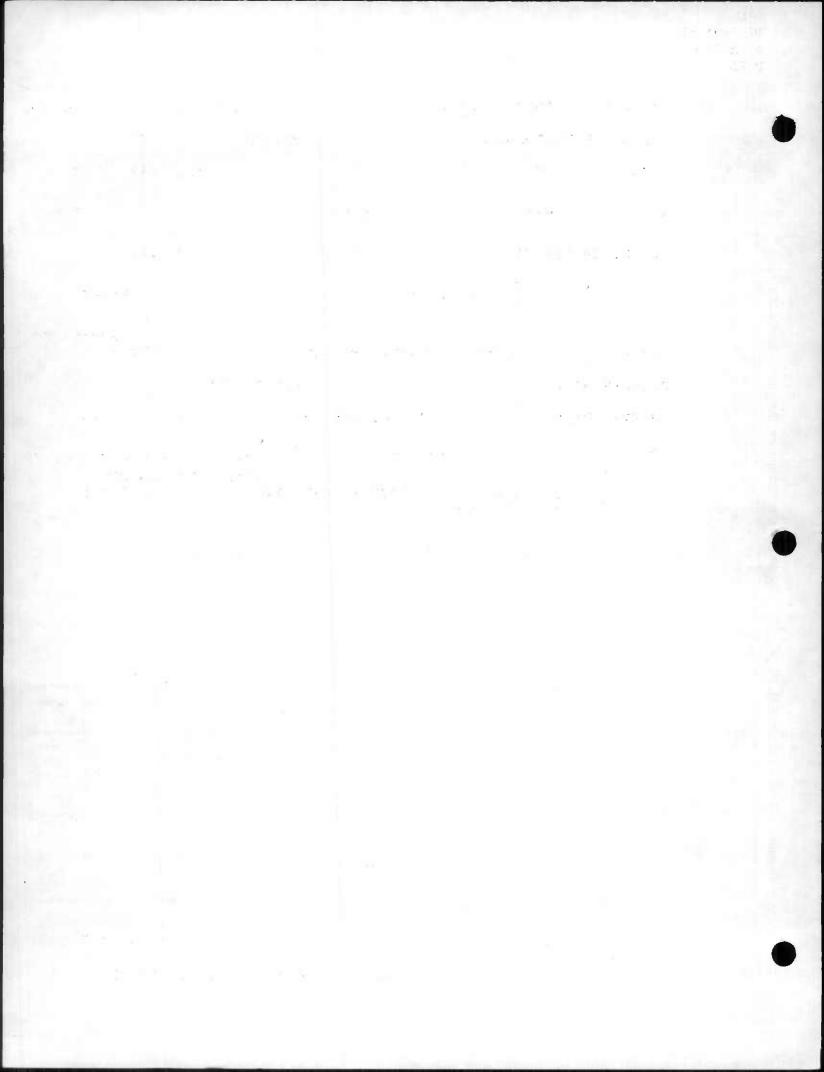


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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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Physician

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Physician /Medical

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29a. Certifier

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29b. Signeture end title of certifier

31. Date filed (Month, Dey, Year)

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24 hours Funeral within 2 o the F

> State Registrar

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29c. License number D23580

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end menner es steted.

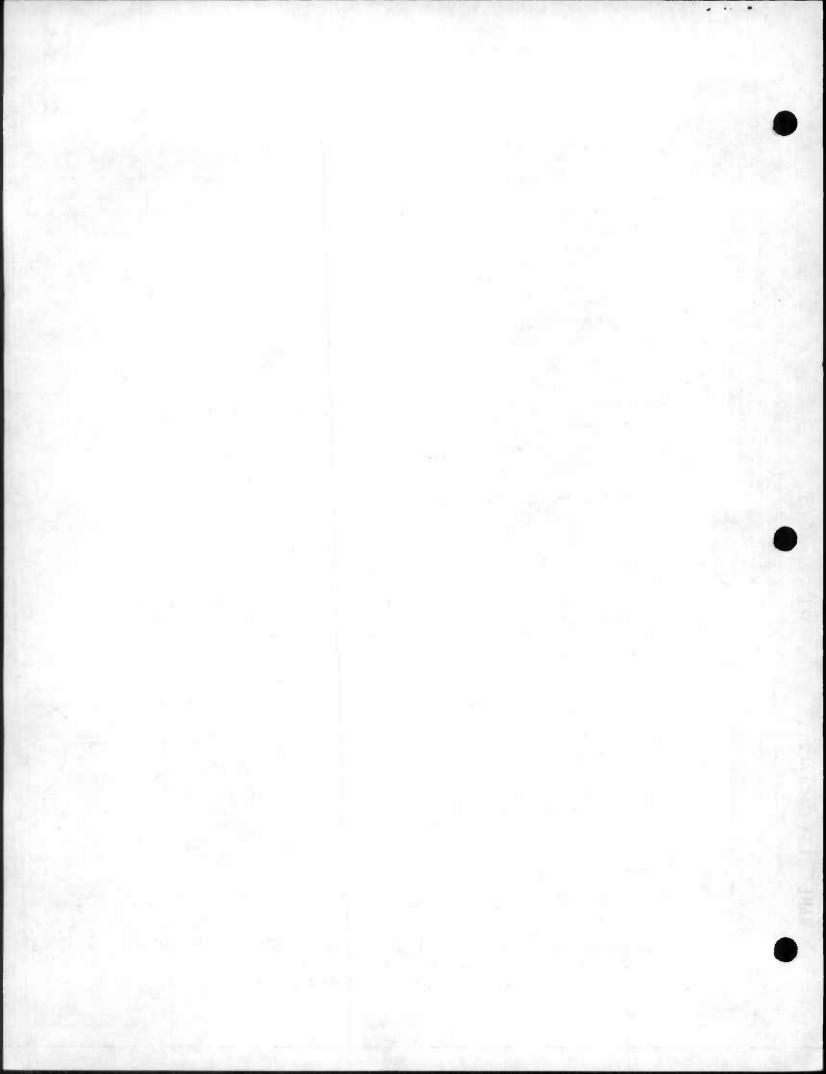
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted.

29d. Data signed (Month, Day, Year) Soplember 6,

AVE, BALTO, MD

30. Name and editions of person who completed cause of death (Item 23a) (Type, Print)

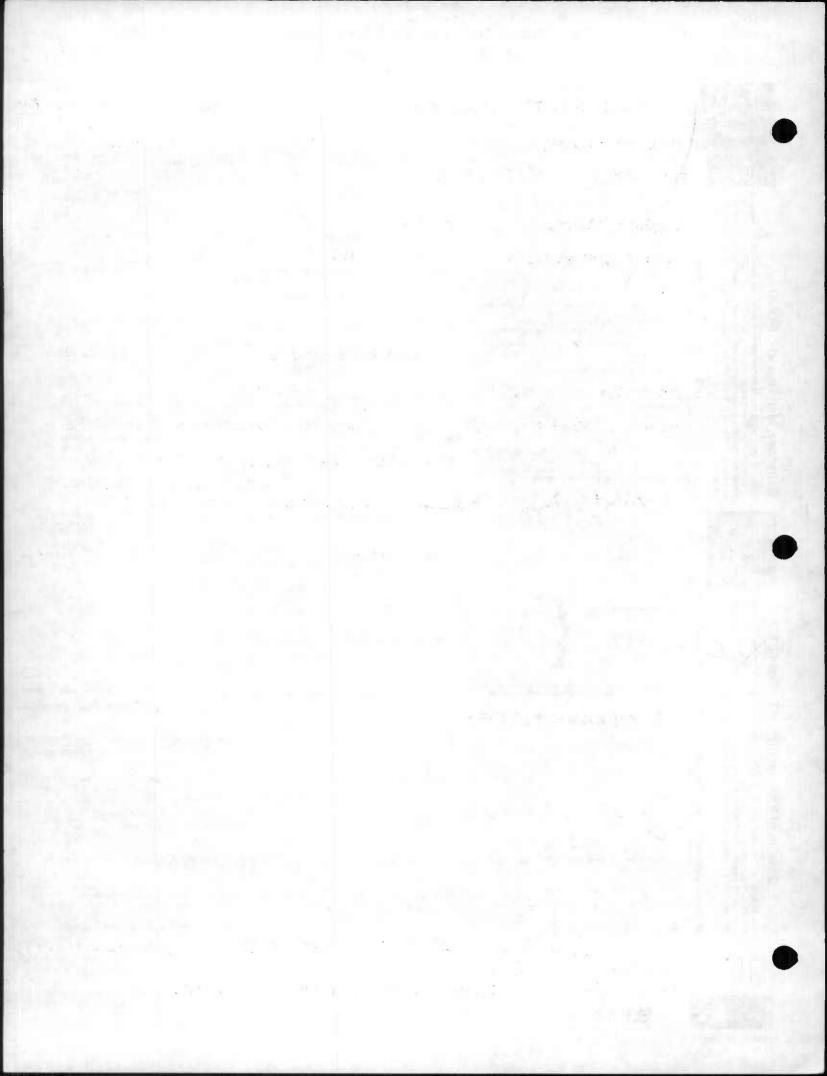
PLANTHOUT 3449 32/Registrar's Signeture



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re,	f Health frem 27 other tr	20a. Meth	od of Dispos	ition		20b. Place of Disposition (Name of							20c. Location - (
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	spltumers ners y fille		ifier 1	Cortifying Ph	yaiclan: To th	e best of my ki	nowledge, deat	occurre	at the ti	me, date and p	lace, and	due to the	ause(s) and ma	nner es s	tated.
	To the Hospital or Attending Physwithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral districtions.	(Chec	ck only 2	☐ Medical Exar		pasis of examination of the states of the st	nation and/or In	vestigatio	n, in my o	opinion, death	occurred	at the time, o	late and place, a	ind due to	the ceuse(s)
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	State	31. Date f	Duleep Praghan 5401 Old Court Road Randallstown, Maryland 21133 31. Date filed (Month, Day, Year) 32. Registrar's Signature												
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State of Maryland / Department of Health and Mental Hygiene

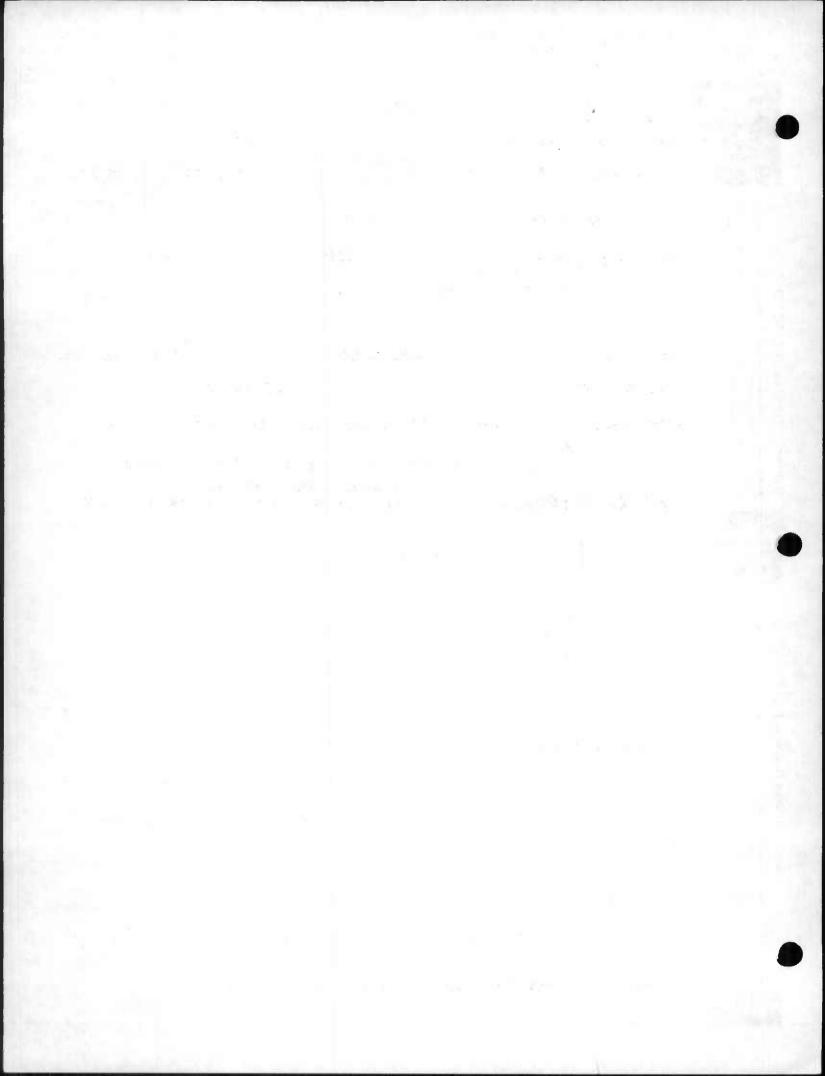
Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth HUBBSISR **Physician** 5.05 AG DAVID F pleruker /Medical 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner MARINER HEALTH OVERLEA BALTIMORE CITY N/A If Under 1 Yaar If Undar 24 Hrs.
Months Deys Hours Min. 8. Dete of Birth (Month, Day, Yo 3/18/20 5. Social Sacurity Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Months 1 □ M 2 □ F 217-07-1499 Yrs. MARYLAND Director 78 Usuel Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours aftar death with the Maryland Depertment of Health end Mental Hyglene. Important: If item 23 e or 28e4 show important: If item 23 e or 28e4 show enty Injury or other transmitter. We have the Mental Ending of the result of the Mental Ending of the result of the Mental Ending of the result of the Mental Ending of 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 X No Director BALTIMORE RIDGELEIGH 10e. Street end Number 10f. Zip Coda 10g. Citizan of What Country? 21234 USA Funeral 1759 WESTON AVENUE 12. Was Decedant Evar in U,S. Armed Forcas? Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Black, White, etc. NO 1942-If Yes, Give Yaer or Detas: 1945 1 Never Married Married Saltimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: þ Specify WHITE 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 8th GRADE MAINTENANCE SCHENUIT TIRE CO. 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be WALTER HUBBS EFFTE PAINTER 0 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) BETTY HUBBS WIFE 1759 WESTON AVENUE BALTIMORE, MD 21234 20b. Place of Disposition (Name of cemetery, cremetery or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burlal 2 Cremetion 3 Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) MORELAND MEMORIAL PARK 9/5/98 HILLENDALE, MD 21. Signature of Funeral Service License 22. Name end Address of Fecility
JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Final disaasa or conditior resulting in death) Examiner Due to (or es e consequence of): Physician/Medical Examiner Sequentially list conditions, if eny, leeding to immediata cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequance of): Box 68760. Due to (or es a consequança of) The law requires that the death certificate signed by the a P.O. I Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the ceuse of death? 1 | Yes 2 | No 3 ☐ Probably 4 ☑ Unknown Records, þ accider Completed 24a. Wes en eutopsy performed? Were eutopsy findings eveileble prior to completion of causa page 2 2 No 1 ☐ Yes 2 No Division of Vital or Attending Physician: 25. Wes case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Plece of Deeth (Check only one) Hospital: Othar: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28e. Dete of Injury (Month, Day Year) 27. Menner of Death 28b Time of 28c. Injury et Work? 28d. Describe how injury occurred After 1 Netural 5 Pending Investigation 1 Yes 2 No death 2 Accident efter deatl 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide 24 hours e Hospital 1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner es steted.

2 Medical Exeminer: On the basis of examinetion end/or invastigation, in my opinion, death occurred at the time, dete end place, and due to the ceuse(s) end menner stated. 29e. Certifier Medical To the Hosp within 24 hor To the Fune complately fi (Check only one) 29d. Data signed (Month, Day, Year) Soplemmy 4th Tripenaeni Seplemby 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Sireesh Tripeuaern 5601 LOCH RAVEN BLVD. BALTIMORE, MD Registrer's Signeture 31. Dete filed (Month, Dey, Year) State

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Registrar

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SEPTEMBER 06 1998 **Physician** Patricia Ann Jackson /Medical 4c. County of Death 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ST. AGNES HEALTHCAKE BALTIMORE If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 63 Yrs. 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 5. Sociat Security Number 217-30-4580 **Funeral** Days 1 □ M 2 TF Months Hours JULY 28, 1935 Maryland **Director** Usuat Residence of Decedent 10d. Inside City Limits permit. Peges 1 end 2 should be filed within 72 hours after death with the Marylen Department of Health end Mental Hygiene.
Important: If item 27 is marked other than "naturel", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location MD Catonsville 1 Yes ZX No Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5023 Wilkens Avenue 21228 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Cotlege (1-4or 5+) 11 Homemaker Domestic 18. Mother's Neme (First, Middle, Majden Surname) 17. Father's Name (First, Middle, Last) Be Louis Schneider Laura Jackson 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Edward L. Jackson/husband 5023 Wilkens Avenue Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removei from State Metro Crematory, Inc. 9/8/98 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Cremation Society of Maryland, Inc. 21. Signature of Funeral Service Licensea C Dawn F. McDonald 299 Frederick Rd. Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each tine. Approximate Intervat Between Onset end Death **Physician** FEW INTRACRANIAL HEMORRAPGE DAYS Immediata Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): FE W CRISIS HUPERTENSIVE DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as e consequença of) Due to (or es a consequenca of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Physi 1 Yes 2 No 3 Probably 4 Unknown þ 24a. Was an eutopsy performed? 24b. Were autopsy findings eveitable prior to Completed completion of ceuse of death? 1 Yes 2 No 1 ☐ Yes 2 ■ No 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ■ Inpatient 2 □ ER/Outpatlent 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 27. Menner of Deeth 28b. Time of 28c. Injury at Work? Certification: 5 Pending 1 Naturel 1 Yes 2 No investigation 2 Accident 6 Coutd not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 Sulcide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours Funaral 29a. Certifie 1 Cortifying Physicien: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and menner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and manner stated. (Check only one) Within 2 To the 8 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) SEPTENBER - 6-1998

Division of Vital Records, P.O. Box 68760, PATRICIA A. JACKSON

altimore, Maryland 21215-0020

Registrar

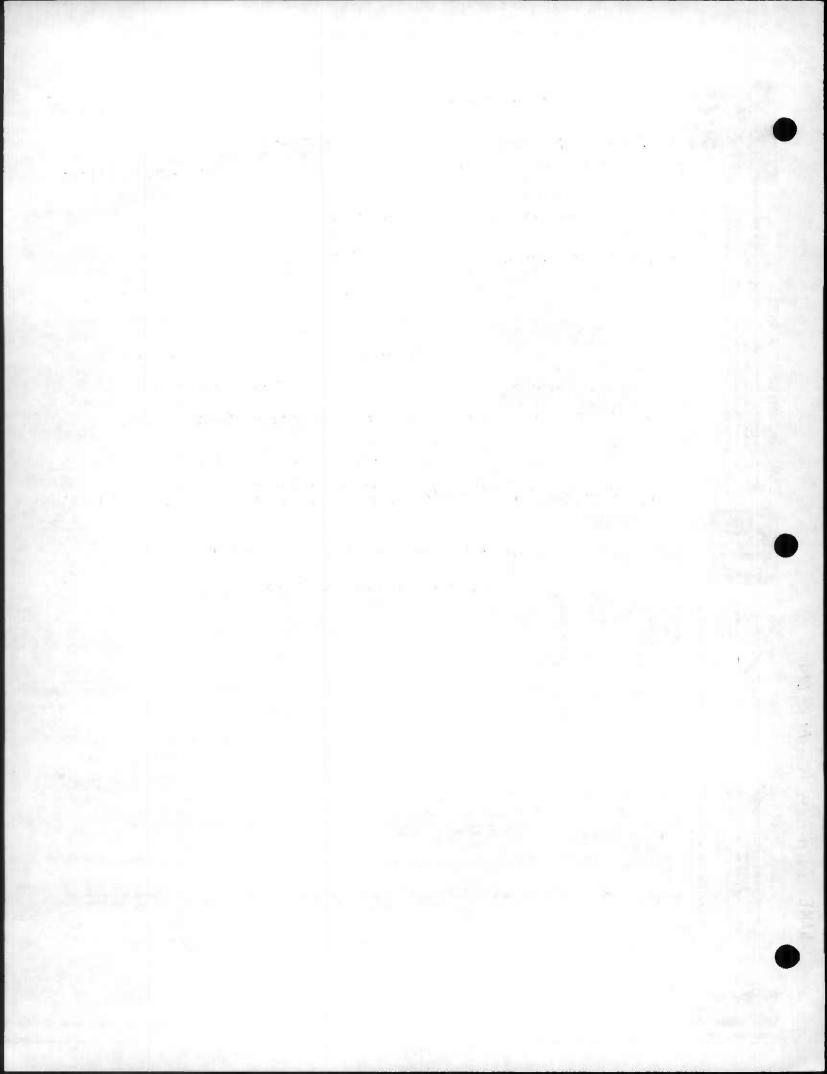
30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)
PALLADINO LUCA 900 CAT 31. Date filed (Month, Day, Year)

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900 32.,Registrar's Signature

CATON AUE

BALTIMORE, MI)



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 3. Time of Deeth 1. Decedent's Neme (First, Middla, Last) Dey **Physician** Jeckson William SEPTEMBER 5, 1998 1142 A.M. cmes /Medical 4b. City, Town, or Location of Daath 4c. County of Deeth 4a Facility Name (If not institution, giva street end number) Examiner Baltin Onder 24 Hrs. Hospita More If Under 1 Year 9. Birthplace (State or Foraign 5. Social Security No 7. Age (In yrs. lest birthday) **Funeral** 10 M 20 F Months Days Hours Min 220.86-4811 Usual Residence of Decedent Yrs. Mary aro Director ammil. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Separament of Health and Mentel Hygiene. The profile of the 22 is marked other than "natural", or items 23s or 28s-5 show my injury or other traumatic event, the Medical Examiner main be notified at 10e. State 10b. County 10c, City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo ld SIGNIFIAC 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street and Number Funeral Was Dacedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race -American Indian. 11. Merital Status Bieck, Whita, atc. 1 Nevar Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0020 Specify: Specify: þ 3 Widowed 4 Divorced DICCK Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) CLOOR 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Jackson Glover tather 2 Dole 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 1812 Md Jeckson cre 20b. Place of Disposition (Neme of cemetery, cremetory or other) Date 20c. Location - City or Town, Stata 20e. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Ramovei from State Baltimore, Marylana 4 ☐ Donetion 5 ☐ Other (Specify) Lemelery 22. Name and Addrass of Home & tuneral 23a Pert1. Enter the disease, or complications that causad the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Balto, Approximete Intervel Between Onset and Death Physician Immediate Ceuse (Finel disease or condition resulting in death) /Medical OS Examiner Due to (or es e consequence of): Examiner and Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Physician/Medicai Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying causa givan in Part I. signed by t 1 Yee 2 No 3 Probably 4 Unknown À 24b. Were eutopsy findings eveilable prior to 24a. Was an eutopsy performed? After this certificate has been si funeral director, page 2 should Completed complation of cause of death? 2 NO 25. Was case referred to medical examiner? Be 26. Piece of Deeth (Check only one) To Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ≥ ER/Outpetient 3 DOA 28e. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 Yes 2 No 2 Accident after deati 6 Could not be determined 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, deeth occurred at the time, data and place, and due to the ceuse(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifie edicai (Check only one) 29c. Licansa number 29d. Dete signed (Month, Day, Year) 29th Signeture end title of certifier and eddress of person who completed cause of death (Item 23e) (Type, Print)

State Registrar

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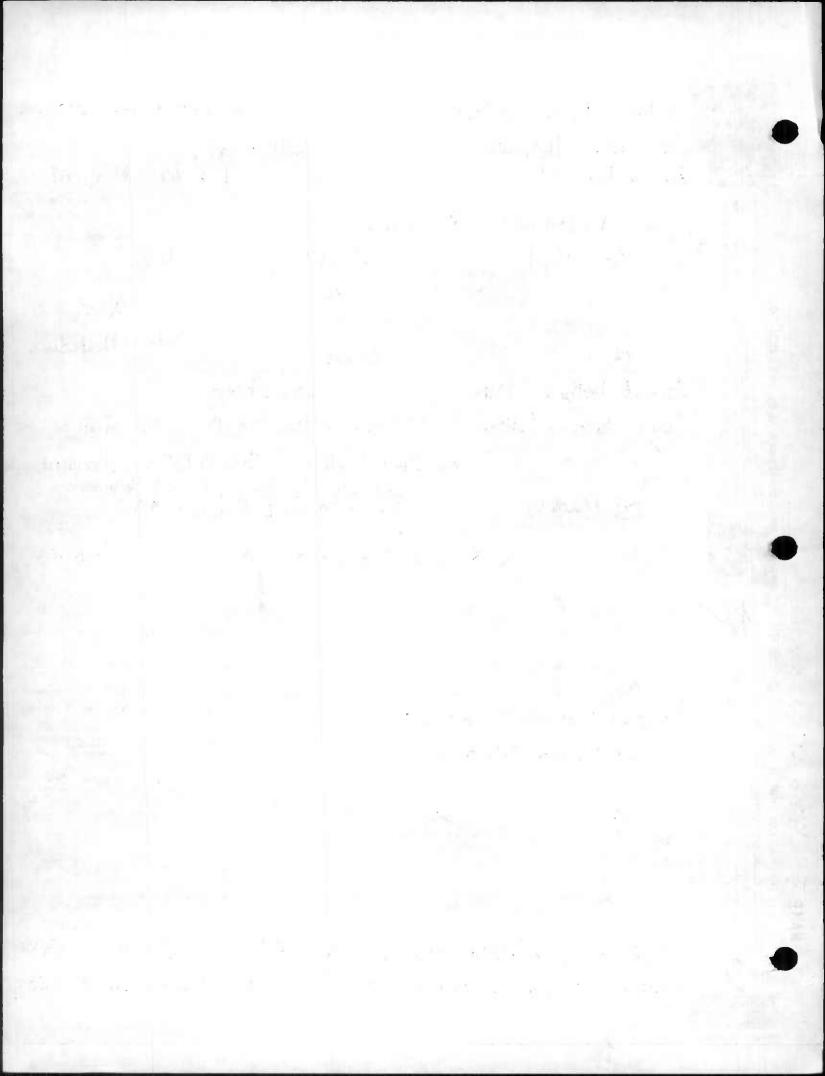
Jackson, William

Tiegistid.

31. Date filed (Month, Day, Year)

8 1998

32. Registrer's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2 Date of Death 3 Time of Death SEPTEMBER 3 1998 5:40P ERS OUISE 4a. Fecility Neme (If not institution, give street and number) City, Town, or Location of Death 4c. County of Deeth Jaltimore 1ERCY - 4 44 Ila Jaris If Under 1 Year If Under 24 Hrs. 8. Dete of Birth Hours Min. Month, Dey, 7. Age (In yrs. lest birthday) Yrs. 5. Sociel Security Number 9. Birthplece (Stete or Foreign Country) D.C 6. Sex Months 1 M 2 34 215-30-8508 OU. Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 TYES 2 No FIMORE 10e. Street end Number 10f. Zlp Code 10g. Citizen of Whet Country? ward 3822 AZU 2121 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☐ NO Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritel Stetus Bleck, White, etc. 1 Never Married 2 Married If Yes, Give Yeer or Dates: 1 Yes 2 No Specify: Specify: 3 Widowed 4 □ Divorced lac 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12+h Attendant illageWash AM 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumane) Bauloe Wlian OFMAN DULSE 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 3822 Hayward leffers-Balto d. 21215 Daunter DORINda. 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete Dete 9.9.98 Downas Mills mol Jappison forest Vet. 4 ☐ Donetion 5 ☐ Other (Specify) me of Funerel Service Licensee 22. Name end Address of Fecility + 20 W =3 FUNGRal march 21215 4300 Wabash Ave. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdlec or respiratory errest, or heart valure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediete Ceuse (Final COLON nknown diseese or condition resulting in death) Sequentially list conditions, if eny, leeding to Immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initialed events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of): Pert II. Other eignificant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 □ Probably ♣ ☐ Unknown 1 Yes 2 No 24b. Were eutopsy findings aveileble prior fo 24a. Was en eutopsy performed? completion of cause of deeth? 217 NO 1 Yes 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 26. Place of Deeth (Check only one) SIE/A MARIS AT MERCY Other: 4 Nursing Home 5 Residence 8 Other (Specify) HOSpicE 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Merymer of Deeth 28b. Time of 28c. Injury et Work? 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No ▲ □ Accident

Box 68760 P.O. **Physician**

/Medical

Examiner

Funeral

Director

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permit. Paga Department

Important: If item 27 any injury or other tr

Physician /Medical

Examiner

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Maryland 21215-0020

Baltimore,

Director

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Certification: To

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3 Suicide

29a. Certifier

4 Homicide

traumatic event, the Medical Examiner must be notified at

or Attanding Physician: The law requires that the death carificate be executed Division of Vital Records.

daath. after death Director:

State Registrar

30. Name end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print) FERRANDO 31. Dete filed (Month, Dey, Year)

29b. Signeture end fitle of certifier

8 Could not be determined

FERRO MD 32. Registrer's Signeture

28e. Plece of Injury - At home, farm, street, fectory, office bullding, etc. (Specify)

Balto

JEC Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion end/or Investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner steted.

29c. License number

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28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

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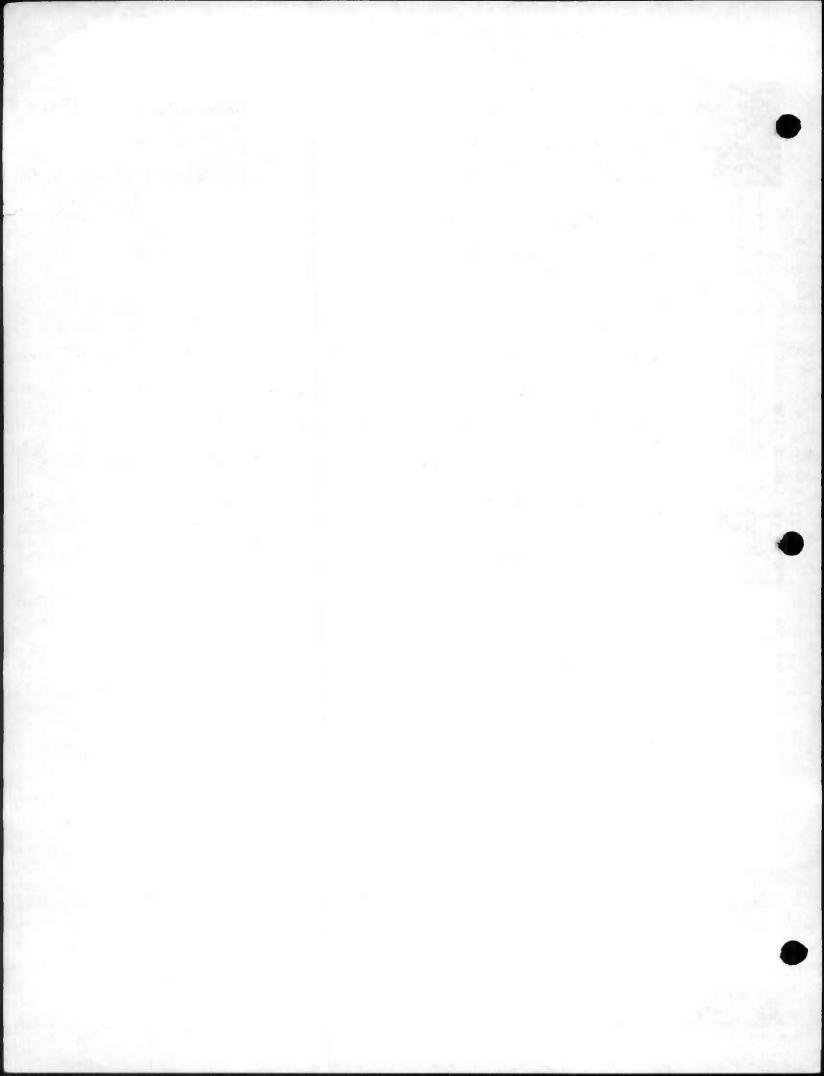
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29d. Dete signed (Month, Dey, Year)

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Edette Jones		State	of Maryland	Department of I I - I 6 - 98 WR Certificate of	Health and Me	ental Hygi	iene	5 5	730:	2
ITEMS: #23 PA	RT I, 27	, 28A-F PER	MEO G765	Certificate of	Death	Re	g. No.	3 %	1000	
	ent's Nama (First					2. Data of Death			3. Time of	Deeth
Physician C	ollin	Everett	Jones			Month August	Day 31	1998	6:02	P.M.
	v Nema (If not in	stitution, give street and n	um <i>ber</i>)		4b. City, Town, or Loc		4c. Cou	nty of Death		

Physician	
/Medical	
Examiner	

4e Facility Nema (If not institution, give street and number)

Funeral Director

death with the Maryland r 28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with I Department of Haalth and Mental Hygiena. Important: if item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Madical Examines must be a say injury or other traumatic event, the Madical Examines must be a altimore, Maryland 21215-0020

> Physician /Medical Examiner

attending physician and for use as the bunal-transit The law requires that the death certificate be executed Box 68760, signed by the a Division of Vital Records, P.O. been sig certificata has b lirector, page 2 s To the Hospital or Attending Physician: within 24 hours after death.

To the Funerat Director: After this certifica completely filled in by the funeral director, ector:

N/A Baltimore ar | If Under 24 Hrs. Sinai Hospital Pediatric Intensive Care Unit 8. Date of Birth Month, Day, Ye June 21, 9. Birthplace (Stata or Foraign 5. Sociel Security Number 7. Aga (In yrs. last birthday) Year 1998 Months 1₽M 2□ F Hours Maryland 213-53-3511 Usual Rasidance of Dacedent 10a. State 10b. County 10c. City. Town or Location 10d. Insida City Limits 1 Yas 2 No Baltimore Director MD. Woodlawn 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? 2309 Rogate Circle Apt. 102 21244 USA Funerai 12. Wes Decedant Evar in U,S. Armad Forces? 13. Was Decedant of Hispenic Orlgin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14 Rece - American Indien 11. Marital Status Bleck, White, atc. 1 ☐ Yas 2 ☒ No If Yas, Giva Yaar or Datas: 1 Navar Married 2 Married 1 ☐ Yas 2 ☐ No Specify: Specify: Black by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) Dependent Child none 18. Mother's Nama (First, Middla, Maidan Surnama) 17. Fathar's Nama (First, Middla, Last) Be Jennifer L. Crocker Clarence Jones III 2 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Typa, Print) 2309 Rogate Circle, Apt. 102, Woodlawn, MD. 21244 Jennifer L. Crocker (mother) 20b. Placa of Disposition (Neme of cematary, cramatory or other place) 20c. Location - City or Town, Stete 20a. Mathod of Disposition 1 Burial 2 Cramation 3 Removel from Stata 9/6/98 Cockeysville, MD. Ashland Presbyterian 4 ☐ Donetion 5 ☐ Other (Spacify) 22. Nama and Addrass of Fecility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, MD. 21204 LEXALLE of complications hat ceused tha daath. Do not antar tha moda of dying, such as cardiac or respiratory arrest, list only one cause on each line. Approximete Intarval Batween Onset end Daath Part I. Enter the diseas shock, or heart failure Immediata Cause (Final disaasa or condition resulting in daath) SHAKEN BABY SYNDROME Dua to (or as e consequance of): Examine Sequantially list conditions, if any, laading to immadiata cause. Entar Underlying Causa (Disaasa or Injury that Initiated avants rasulting in daath) Lest Dua to (or as a consequence of): Physician/Medicai Dua to (or as e consequanca of) 23b. Did tobacco usa contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 Yes Š 24b. Were autopsy findings aveilable prior to complation of causa of daath? 24a. Was an autopsy performad? Completed 1 XYas 2□No 1 Kas 2 No 25. Was casa rafarred to medical axaminer? 26. Plece of Death (Check only one) Be To Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Home 5 Rasidance 6 Othar (Specify) 1 XYas 2 No 28d. Dascribe how Injury occurred 27. Menner of Death 28b. Tima of 28c. Injury at Work? Certification: 28a. Data of Injury (Month, Day Year) P Pending 1 Natural 1 Yes 2 No invastigation 8-25-98 CHILD ABUSE 2 Accidant 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 2309 ROGATE CIRCLE APT. 102 BALTIMORE CO, MD 6 Could not be determined 3 ☐ Sulcide 4 ☑ Homicide 28a. Placa of Injury - At homa, farm, streat, factory, offica building, afc. (Specify) 1 Cartifying Physician: To tha best of my knowledge, death occurred et the time, dete end place, and dua to tha cause(s) end mannar as stated 29a. Cartifier edicai 25 Medical Examinar: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. (Check only 29d. Data signed (Month, Dey, Year) 29b. Signeture end title of certifiar 29c. Licansa number bute, w O.C.M.E. September 01, 1998 30. Nama end eddress of person who complated causa of deeth (Itam 23a) (Type, Print)

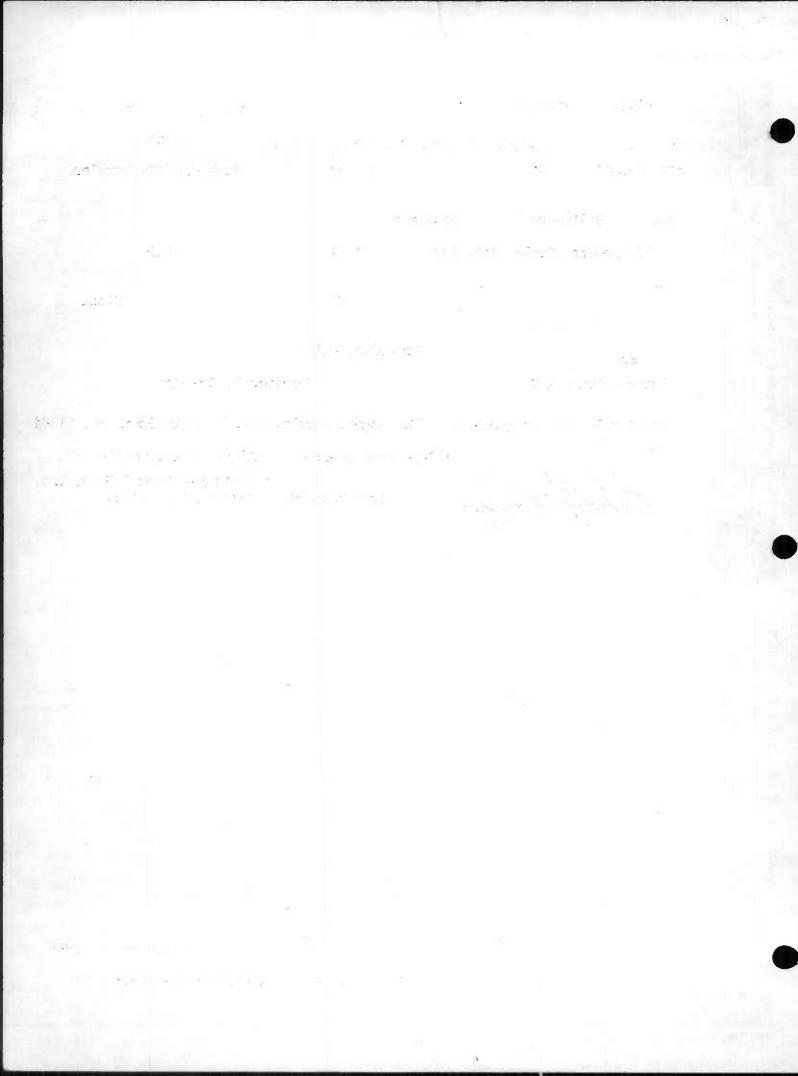
111 Penn Street, Baltimore, Maryland 21201

State Registrar Vennis

0 31. Data filad (Month, Day, Year)

8

32. Registrar's Signature



B.K.S
AMEND: #27 PER MEO G764 State of Maryland / Department of Health and Mental Hygiene
WILLIAM KRENKOWITZ ITEMS: 23 PART I, 27, 28A-F PER Certificate of Death

Amend: #4a Per MEO Film G763 9-10-98RC

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Reg. No.

Reg. No. 27303

	1
Physician	
/Medical	_
Examiner	4

Funeral Director

permit. Pegas 1 and 2 should be filed within 72 hours after deeth with the Merylend Department of Health and Mantal Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 ahow eny injury or other traumatic event, in Medical Exercises must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be associted within 42 hours after death.

To the Funeral Director: After this cardificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760.

1. Decedent's Nama (First, Middle, L William Patri		renkowi	+ 7					2. Dete of De Month SEPT	Day	Year	3. Time of Deeth
4e Fecility Name (If not Institution, gr			LZ			4b. City. To	own, or L	ocation of Deat		nty of Deeth	1
8354 SYCOMORE R	225							/ILLE		JE ARU	
	000	4 SYCAMOR		If I Inde	ar 1 Yeer						
	Sex 1.24M 2.□F	7. Age (In yrs.		Months		Hours	Min.	8. Dete of Bi (Month, Di	ey, Yeer)		place (Stete or Foreign ntry)
267-29-8682			43 Yrs.				<u></u>	8/23/1	955	New	Jersey
Usuel Residence of Decedent 10e. State 10b. County		10c Cit	ty, Town or Lo	cation						1	10d. Insida City Limits
		100. 01	ly, TOWN OF LO	Cation							1 ☐ Yas 2 🛣 No
MD Anne Ar	undel	Mi	llersv	ille							TE TAS ZAJIVO
10e. Street end Number				10f. Zi	ip Code				10g. Citizen	of Whet Cou	intry?
8354 Sycamore Ro	ad			21	1108				USA		
11. Maritel Stetus		cedent Ever in U	,S. 13. \	Was Dece	edent of I	Hispenic Or	rigin? (Sp	ecify Yes or N		leca - Ameri	
1 ☐ Nevar Married 2 ☐ Married	Armed F	orces? 2 ANo						Rican, etc.)	E	Black, Whita	, etc.
3 ☐ Widowed 4 ₺ Divorced	If Yes, G	live Dates:		1 Yes	2 X No	Specify	:		Spe	city: Wh	ite
15. Decedent's E			16e. Deced	ient's Usi	uel Occur	netion			16b. Kind of	f Business/ir	
(Specify only highast g	eda completed)	(Give	kind of w	rork done	during mos	st of work	king			,
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			FOLI	X111 (. Ope	_		e (First, Middle	Brev		
17. Fethar's Nema (First, Middla, Las	1)					18. Moth	ers Nem			ieme)	
William A. Krenk	owitz					Hele	en	Hoffm	an		
19e. Informent's Neme/Reletionship	(Type, Print)		19b. Mailin	ng Addres	ss (Street	t end Numb	er or Rui	ral Route Numb	per, City or Tox	wn, Stete, Zi	ip Code)
Helen Whittaker	/ moth	er	8354	Syca	amore	Rd.	Mil1	ersvil	le, MD	21108	
20a. Method of Disposition			Pleca of Dispo	sition (Ne	eme of	en l		Date	20c. Locatio	on - City or T	own, Stete
1 ☐ Buriel 2 ☐ Cremetion 3		n State	cametery, cren			100)					
4 □ Donetion 5 □ Other (Spec	**	Me	tro Cre					9/8	Catons	sville	, MD
21. Signature of Furieral Service Lice	7000 De a a se		Ba	arran	ico 8	Sons	PA	Severna	a Park	Funer	al Home
23a / art1. Enter the disease, or cor hock, or heart feilure. List only	nplications that y one cause on	causad the deet eech line.	th. Do not ent	er the mo	de of dyl	ng, such es	s cardiac	or respiretory	errest,		Approximete Intervel Between Onsat and Death
Immediate Cause (Final			THE DE	CORRE							
disease or condition resulting in deeth)	a	2F1	ZURE DIS	SUKUE	Κ						
		Due to (d	or es e conseq	quence of):					1	
	b									ì	
Sequentially list conditions,		Due to (c	or es e conseq	uence of):						
Sequentially list conditions, if eny, leeding to immadiata cause. Enter Underlying Cause (Disease or injury											
that initiated events	C	Due to (o	or as e conseq	uence of)):						
resulting in death) Lest										1	
	d										
Date Other Janes		death to a second	M'- 1- M-	a da ab da co		i- D- d		ook Die	lankaana waa	a a matellia sate	to the source of death?
Part II. Other eignificant conditions	contributing to d	death but not res	sulting in the ui	nderlying	cause gr	ven in Pert	1.				to the cause of death?
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									s en eutopsy ormed?	6	Vere eutopsy findings veileble prior to ompletion of causa if deeth?
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25. Wes case referred to medical exeminer?	Hospital:				Oti	ham		th (Check only			
XXYes 2 No	1		ER/Outpatien		JUA	4 LI N	ursing Ho	ome 5 A Res			ulty)
27. Menner of Deeth 1 ☐ Naturel 5 ☐ Pending		nth, Dey Year)	28b. Time of injury		28c. Inju Wo				how injury oc		TDUCK
2 Accident investigetion			1:50	М		Yes 2X	I No		ED IMPAC		
3 Suicide 6 CA Could not determine	28e. Pled	ce of Injury - At hi ding, etc. (Specif KING LOT	ome, farm, str	eet, fecto	ry, offica			28f. Location City or To	(Street end Number)	mber or Ru 3989 HOI	LINSFERRY RO
	PAR	KING LOT							RE MARYL		
							-		12 PE TO 1 PE	11110	

							1. Yes 2□No	1.2 Yes	2 N
25. Wes case referred t	o medicai				26. Plece	e of Deeth (C	neck only one)		
exeminer? XXYes 2□ No		Hospital: 1 ☐ Inpatienf 2 ☐	ER/Outpatient	3	DOA Other: 4 Nu	ursing Home	5 Nesidence 6 □Oth	ar (Specify)	
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3 Suicide 6- 4 Homicide	Could not be determined	28e. Plece of Injury - At h building, etc. (Special PARKING LOT	ome, farm, stree fy)	t, fect	ory, offica		Location (Street end Numb City or Town, Stete) 398		Yumb ERR

29a. Certifier (Check only one) 1. Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and menner as stated.

MM Medical Examiner: On the best of axamination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

Y ROAD

29b. Signatura and titla of certifier

29c. Licansa number O.C.M.E

29d. Dete signed (Month, Dey, Year) 4, 1998 SEPT.

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

Stephen S, ICa 31. Dete filed (Month, Dey, Yeer) SEP 0 8 1998 111 Penn Street, Baltimore, Maryland 21201 adrnt 2, 111
32. Registre's Signeture

State Registrar

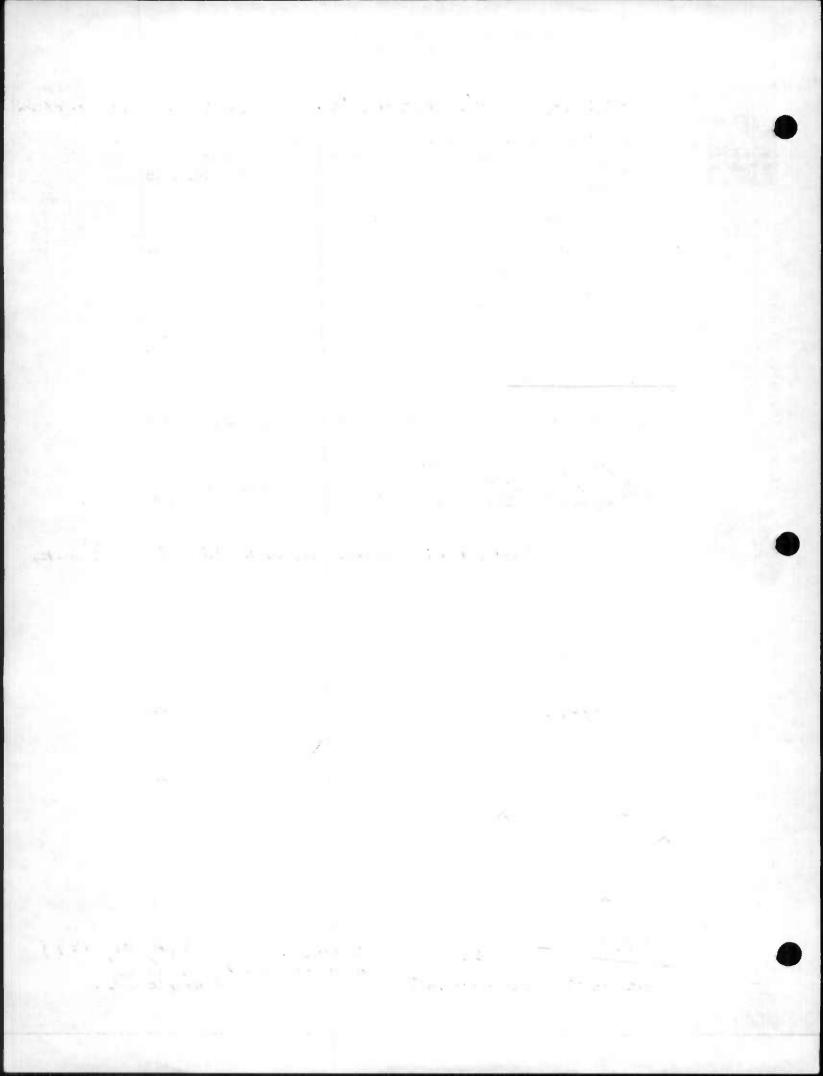
Medical

AND THE SPECIAL SECTION THE PARTY OF THE P Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Amend: #17 Per FH Film G763 9-8-98RC Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month KEARNEY MATTYE G. 48am SEPT /Medical 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Howard County General Hospital Columbia Howard 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1□M 2XF Days 254-62-2187 59 Yrs. Director Oct. 10, 1938 GA Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Exampler must be notified at Howard Columbia 1 ☐ Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g, Citizen of What Country? 6660 Farbell Row 21045 USA 12. Wes Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: by Specify: Black 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiene. Important: if item 27 is marked other than "rany injury or other traumatic event, and Montal Dinca. Good Shepherd Elementary/Secondary (0-12) College (1-4or 5+) School Teacher School 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) (Unknown) Williams WALTER WILLIAMS, SR. Annie L. Hansbrough 19a. Informent's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Mac A. Kearney (Husband) 6660 Farbell Row, Columbia, MD 21045 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 9/6/98 Armour Cemetery Loubell, GA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Witzke Funeral Homes, Inc. 5555 Twin Knolls Rd. Columbia, MD 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Interval Between Onset end Deeth **Physiclan** /Medical Immediate Cause (Final metastatic Colon Concer to disease or condition resulting In death) Examiner Examiner The law requires that the death certificate be executed physician and s the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in deeth) Last Due to (or es a consequence ot) Box 68760 Physician/Medical Due to (or as e consequence of) use P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by i 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were eutopsy findings eveilable prior to completion of ceuse of death? 24e. Was en eutopsy performed? Be Completed s certificata has t director, page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: director, 25. Was cese reterred to medical 26. Plece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28e. Date of Injury (Month, Dev Year) 28c. Injury et Work? 28d. Describe how Injury occurred 28b. Time of After spital o.
44 hours after des.
-vral Director: Atte. 1 Naturel 5 Pending 1 Yes 2 No 2 Accident Investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide in 24 hous.
The Funeral Discal 29a. Certifier To the Hosp within 24 hos To the Fune completaly fi 1💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) end menner as stated. 2 Medical Examiner: On the besis of examination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) and menner steted. 29b. Signature end title of certities 29c. License number 29d. Dete signed (Month, Dey, Year) 241139 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) How and CHEMENT KNIGHT, 31. Date filed (Month, Day, Yeer) SEP 0 8 1998 32. Registrar's Signature Registrar

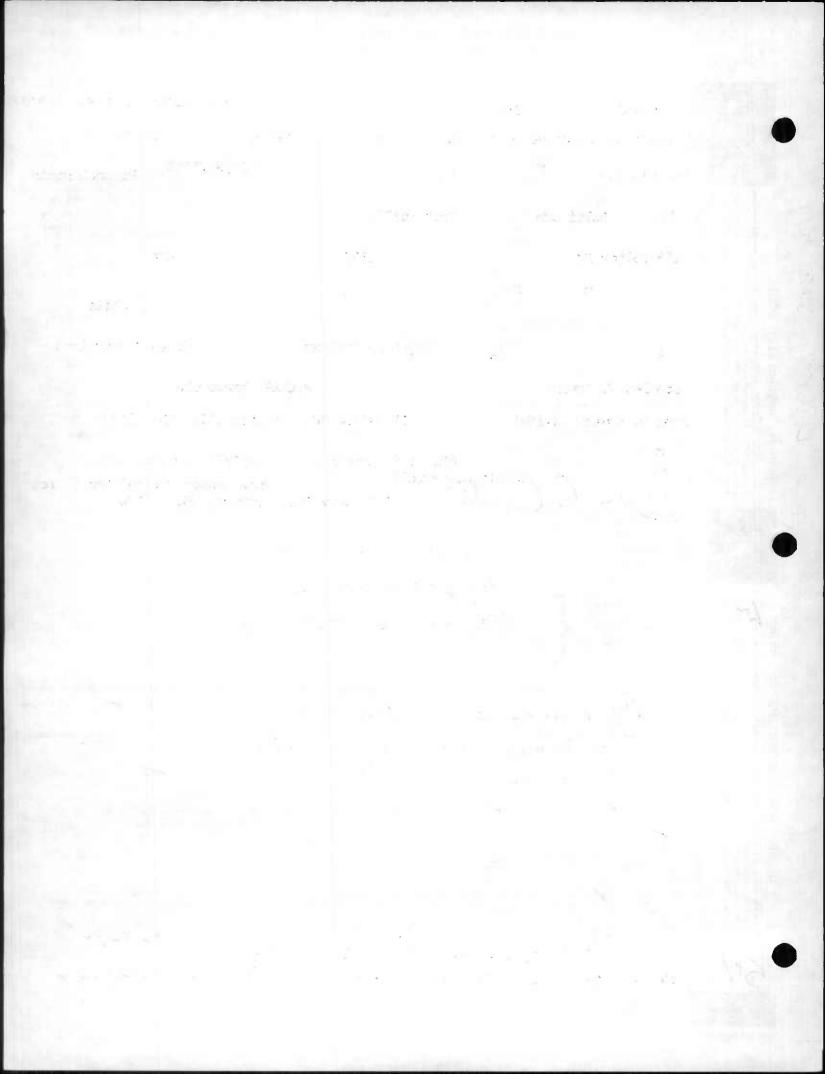
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				f Maryland		tificate of				Reg. No. 9 8	273	05	
Physician /Medical	1. Decedent's Neme	ey J.	Lowi						2. Dete of De Month SEPTE	EMBER 3	3, Year 1998	me of Death 9:00A	
Examiner	4a Fecility Neme (II				CENT	סמה	4b. City, Tow		ation of Deeth		of Death		
	5. Social Security N	R BALTI		7. Age (In yrs. las		If Under 1 Year			8. Dete of Bir			tete or Foreign	
Funeral Director	022-01-89	50	M 2□ F	82	Yrs.	Months Deys	Hours	Min.	8. Dete of Bir 02/287.	1918	9. Birthplace (S Country) Massachi		
land	10e. State	10b. County		10c. City,	Town or Lo	cation			10d. Inside City Limi				
Mary 1 sh	MD	Baltimo	re	Luth	hervi	lle			1 □ Yes				
vith the Mar or 28s-f s be notified Director	10e. Street and Nun	nber				10f. Zip Code				10g. Citizen of	Whet Country?	- 1	
23a o	215 Felto	on Rd.		21093						USA	USA		
on 72 hours after death with the Maryland "natural", or frems 23a or 28a-f show existed Exercines rouge to notified at leted by Funeral Director	11. Maritel Stetus 1 Never Marrie	ed 2 Married	12. Wes Dece Armed Fo 1 X Yes If Yes, Giv Yeer or D	2 □ No ve		Wes Decedent of f Yes, specify Cub 1 ☐ Yes 2 ☑ No		in? (Spec , Puerto R	eify Yes or No lican, etc.)	Ble	14. Race - American Indien, Bleck, White, etc.		
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4 4 4 4	19e. Informent's Na					ng Address (Stree							
Health em 27 other tr	Anne S. La		wife)	20h Pla		Felton 1		LULIE	Pete		21093 City or Town, St	ete	
	1 € Burial 2 [20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete											
Department of mportant: If any injury or once.	-	4 Donetton 5 Other (Specify) Mt. Maria Cemetery 9/7/98 Towson, MD.											
Departm Importar any inju	21. Signature of Ful	neral Service	openn:	is Cocai	rrolf	. Name end Addr	ess of recility	Rucl	C Tows	on Funer	ral Home	, Inc.	
hysician	23a. Part1 Enter the	ne diseese, or com t feilure. List only			Do not ent	^	ing, such es c	cardiac or	VSON, I	MD. 212 rrest,	Appro	eximate el Between t end Death	
Medical xaminer	Immediate Cause (disease or condition resulting in deeth)	Finel 1	θ	Curd Due to (or:		Hrr	e57	•			I		
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physician and stransit tha burial-transit	Sequentially list cor if eny, leeding to im cause. Enter Unde Ceuse (Diseese or	nditions, mediate	b	Dy to (or e	es e conseq	mence of).	i.do:	618					
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rector, pag	25. Wes case refer	ed to medical					26. Plece	of Death	(Check only	one)			
0 0	examiner?	No	Hospital:	Inpatient 2 E	R/Outpatier	nt 3 DOA	ther: 4 Nur	rsing Hor	ne 5 Resi	dence 6 Oti	her (Specify)		
tar th naral	27. Manner of Deeth	5 Pending	28e. Dete	of Injury th, Day Year)	28b. Time of Injury	f 28c. Inju	ury et ork?	2	8d. Describe	how Injury occu	rred		
daath. stor: Aftar t y the funar Cation:	2 Accident	Yes 2 1	. 6.1										
Tite of	3 Suicide 4 Homicide	6 Could not be determined	Zoe. Plece	of Injury - At homing, etc. (Specify)	ne, ferm, str	reet, fectory, office	•	2		Street and Num wn, Stete)	ber or Rural Rout	e Num <i>ber</i> ,	
within 24 hours after of To the Funeral Direct complately filled in by Medical Certifi	29a. Certifier (Check only one)	10 Certifying Pt 2 Medical Exam	niner: On the bi									euse(s)	
To the comple	29b. Signature and	14/	1 1		>	2	127 3	3 3		9-	3 - 98		
121	30 Neme and other	ass of pareon with	completed caus	se of death /Item *	23a) (Tuno	Print)	21						
21/	30. Neme end eddre	Brah	n M	7 76	20	York 1	ed	10	WSOI	V, MI	12/20	4	

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State Registrar 31. Dete filed (Month, Dey, Year) SEP 0 8 1998 32 Registrer's Signeture



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death LYNCH 0145 AM JOHNSON RUBY SEPTEMBER S, 1984 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Randallstown Northwest Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Days | Hours | Min. | (Month, Day, Year) 7. Age (In yrs. last birthdey) 9. Birthplace (State or Foreign Days 10 M 20 F Months Yrs. 213-32-1397 66 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Yes 2 No Baltimore MD NA 10e. Street end Number 10f. Zlp Code 10g. Citizen of What Country? 21215 U.S.A. 6945 Blanche Road 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 □ Never Married 2 □ Married 1 Yes 2 No Specify: 3 □Widowed 4 □ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Social Security Elementary/Secondary (0-12) College (1-4or 5+) Clerk Admin. 12th grade 17. Fether's Name (First, Middle, Last) yrs 18. Mother's Name (First, Middle, Meiden Sumame) Marcella Moss Robert Craig 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Marcella Hines 21215 6945 Blanche Road, Baltimore Md 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/10/98 Arbutus, Md Arbutus Memorial 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March F/H West 4300 Wabash AVe, Baltimore Md 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21215 Approximate Intervat Between Onset and Death METASTATIC BREAST CANCER Immediate Cause (Final disease or condition resulting in death) 4 MONTHS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or es a consequence of): Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown MELLITUS DIABETES 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2000 1□ Yes 2□ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27 Manner of Death 28c. Injury et Work? 5 Pending investigation 1.PTNatural 1 Yes 2 No 2 Accident 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Physician/Medical Examiner þ Completed

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attending physician and for use as the bunal-transit the a signed by the should should has cartificate

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural". And price in the page of the permantic events.

the Maryland

law requires that the death certificate be executed The Attending Physician: this funeral After t er death. ector: Aff by the fur

Physician

/Medical

Examiner

Division of Vital Records, P.O. Box 68760 Olive Olive

Certification: edicai

> State Registrar

29b. Signature and title of certifier

29c. License number 37333

1 Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) SEPTEMBER 5, 1998.

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

21133 9121 Satye Hill Rd. , BALTO. MD

31. Date filed (Month, Day, Year)

4 Homicide

(Check only one)

29a. Certifier

SEP 0 8 1998

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32. Registrar's Signeture

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Piease Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

				C	ertificate of	Death	Reg	. No. 98	27307	1		
	Physician /Medical		1. Decedent's Neme (First, Middle, Last) WILLIAM GARRETT LUMPKIN						3. Time of De			
	Examiner	4e Eacility Neme (If not institution, s Saint Joseph	nive street and number) Medical	Center		4b. City, Town, or Lo TOWS 01		4c. County o	of Deeth altimore			
	uneral irector	223-07-7251	Sex 7. Age	e (In yrs. last birthd 88 Yrs	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) Mar 3, 1	(ear) .910	Birthpiace (State or F Country) Virginia	oreign		
5-0020 72 hours after death with the Maryland	or 28a-f show be notified at Director	Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Baltimore Towson							10d. Inside City I			
leath with t	of thems 23a or 2 other must be n Funeral Dir	800 Southerly Ro	oad, #1312	Ever in U.S.		1286		g. Citizen of W US				
0020 ours after o	by	1 ☐ Never Merried 2 ☑ Merried 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?		I3. Was Decedent of I if Yes, specify Cub		Rican, etc.)		k, While, etc.			
within	The Principal	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	pation during most of working d)			siness/Industry						
Pu si	avent, Be Co	17. Fether's Neme (First, Middle, La		AQV	ertising Sa	18. Mother's Name	(First, Middle, Ma	aiden Sumame				
arylan should be	marked matic a	Robert Pierce	ng Fa	renhol								
Baltimore, Maperit. Pages 1 and 2:	i. If Itam 27 is marked other y or other traumatic avent, To Be C	Gertrude Margare 20e. Method of Disposition 1 X Burial 2 Cremetion 3 4 Donetion 5 Other (Spe	t Lumpkin (Wife 800		y Road #13	Date 20	on, MD oc. Location - (21286 City or Town, Stete			
Baltir Departme	important: any injury once.	21. Signefure of Funeral Service Lin	Lawson	ess of Facility	Uomo		m, Maryland					
		Martin D. Lawson 6500 York Road, Baltimore, Maryland 23a. Pertl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heert feilure. List only one cause on each line.										
/M	esician ledical aminer	Immediate Cause (Final disease or condition resulting in death)	SUBDURA	Due to (or as a cor	TOMA		32. 304		Interval Betwee	ath		
c 68760, artificate be exacuted	signed by the attending physician and do detached for use as the burial-transit dby Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): Due to (or es e consequence of):										
O. Box	d by the attendin latached for use. Physician/M	Pert II. Other aignificant conditions	tribute to the cause of c									
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I Rec	10 N O						1 ☐ Yes	2X No	of death?			
	ertificati ector, pu Be Co	25. Wes case referred to medical				26. Place of Deeth			TEL TOS ZEALAG	,		
of Vita Physician:	this ceral direct	examiner? 1 Yes 2 No	Hospitat: 1 Inpatie		Itlent 3LI DOA		ne 5 Residen	ce 6 □Othe	r (Specify)			
ision trending death.	tor: After the fune cation	27. Menner of Death 1 Neturet 5 Pending 2 Accident investiget 3 Suicide 6 Could not	be one Diago of take	rk? Yes 2 □ No	28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number,							
Div oltal or A	illed in b	4 Homicide determine	building, etc	(Specify)			City or Town,	Stete)		,		
To the Hospital within 24 hours	Completely filled Medical Ce	one) 2 Medical Ex	Physician: To the best of aminer: On the besis of end menner sta	examinetion and/o	r investigation, in my o	opinion, death occurre	ed at the time, dat	e end place, a	nd due to the cause(s)			
To To	000 N	29b. Signeture end title of certifier	no	Thos	29c. Licens D3Ø26		29d. Date signed (Month, Day, Year) 9-3-98					
	10	30. Name and address of person who		-	ROAD, TOW	ISON, MAF	RYLAND :	21204				
	State Registrar	31. Dete filed (Month, Day, Year) SEP 0 8		r's Signeture	G. Spor	K						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth **Physician** August 27, 1998 Ora McKov 6:30p /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not institution, give street end number) Examiner Gilchrist Center for Hospice Care Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) | Sept 28,1921 Birthplece (State or Foreign Country) NC -7. Age (In yrs. last birthday) 1 □ M 2K F 578-28-2618 76 Usuel Residence of Dacedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location tX Yes 2 □ No Director Md N/A Baltimore 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street and Number 2315 Longwood Street 21216 טטטטטט Funeral Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S Armed Forces? 1 Yes No 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐No Specify: Specify: Black þ 3 Widowed M Divorced Yeer or Detes: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bakery Baker 12th 17. Fether's Neme (First, Middle, Last) 18. Mothar's Name (First, Middle, Melden Sumame) Be Effie Fellows Ira Baker 19b. Malling Address (Straat and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Ralationship (Type, Print) 4302 Connecticut Avenue Baltimore, Md 21229 Walter Stewart (Son) 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XDBurial 2 ☐ Cremetion 3 ☐ Removal from Stete 9/02/98 Randallstown, Md King Mem Park 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility Caple Funeral Service of Funeral Service Lice 5502 Winner Avenue Baltimore, 21215 ease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, the one cause on each line. Approximete Interval Betwaen Onset and Death caranomatous Menmontis Immediate Ceuse (Finel diseese or condition resulting in death) breast Examiner Sequentially list conditions, if any, leeding to immediate causa. Enter Underlying Ceuse (Disaasa or Injury thet Initieted events rasulting in deeth) Lest Due to (or es e consaquança of): Physician/Medical Due to (or as a consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? heart disease 1 Yes 2 No 3 Probably 4 Unknown þ levotiz + vascular heart 24b. Were eutopsy findings available prior to completion of cause of deeth? 24e. Wes en eutopsy Completed disease 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Placa of Death (Check only ona) ospice Other: 4 Nursing Home 5 Residence 6 Other (Specify Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 2 No 1 Yes 27. Mary ar of Deeth 28b. Time of 28d. Dascribe how Injury occurred 28a. Data of Injury (Month, Dey Year) 28c. Injury at Work? Certification: Netural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 ☐ Sulcide Place of Injury - At homa, farm, street, fectory, office building, etc. (Specify) 4 Homicide

Certifying Physician: To tha best of my knowledga, death occurred et the time, date end place, and due to the cause(s) and manner es steted. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, daeth occurred et the time, data end place, end due to the ceuse(s) end menner steted.

32. Registrer's Signature

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29d. Dete signed (Month, Dey, Year)

TOWSON Md. 21204

State Registrar

Funeral

Director

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Hygiene.

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29e. Certifier

(Check only one)

30. Name and edd

29b. Signature and fitte

31. Dete filed (Month, Day, Yeer)

ar death.

offer of Hospital 24 Hours Funeral

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Box 68760,

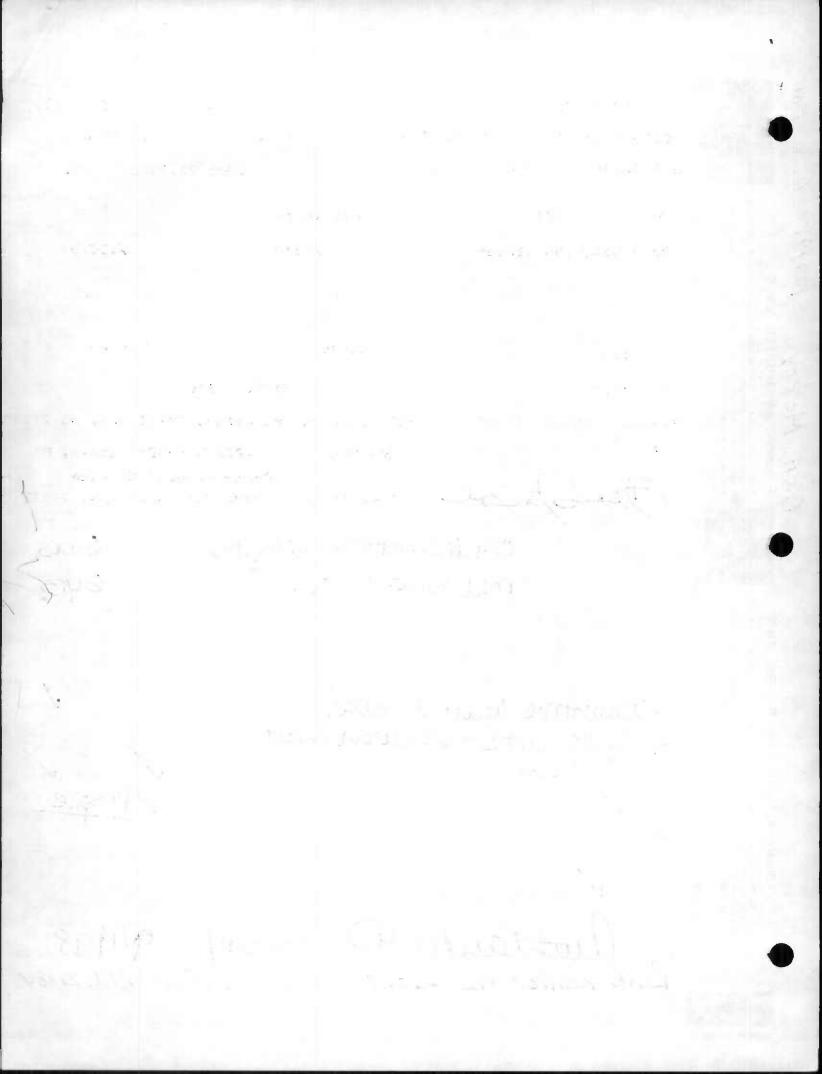
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Division of Vital Records,

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McKoy

with the Maryland



O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

MP

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

0 8 1998

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32. Registrer's Signature

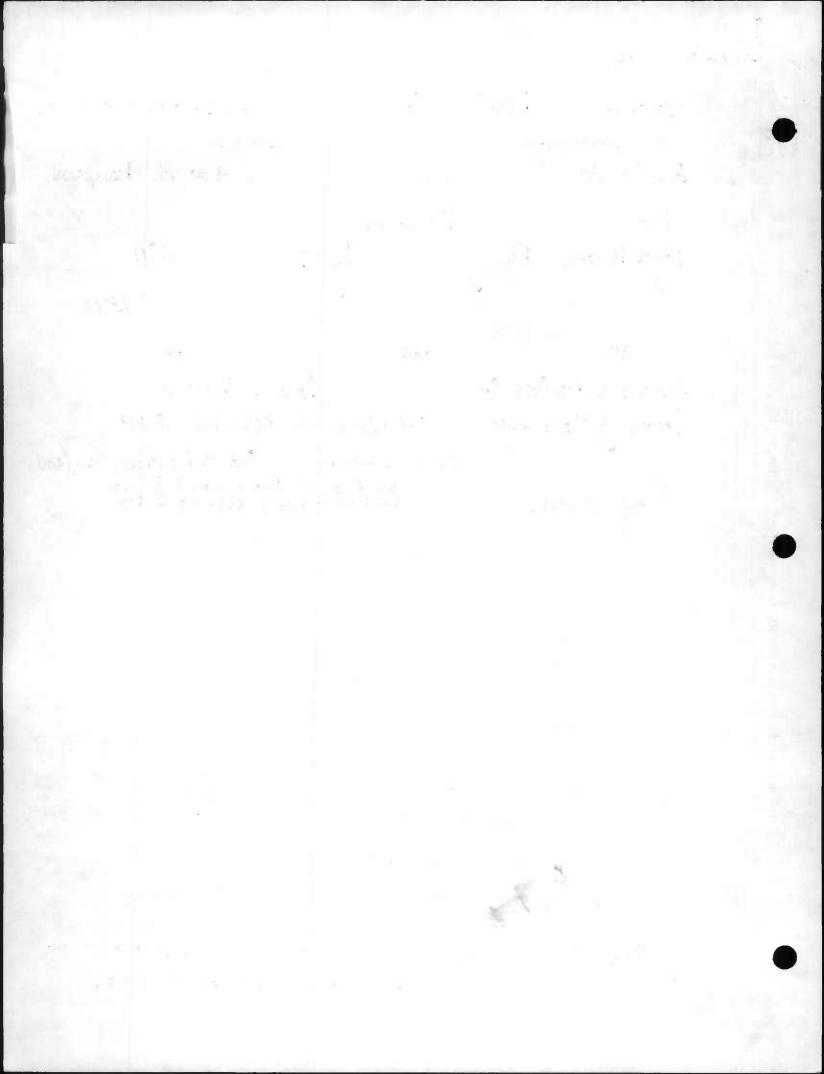
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SEPTEMBER 04, 1998

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31. Date filed (Month, Day, Yeer)

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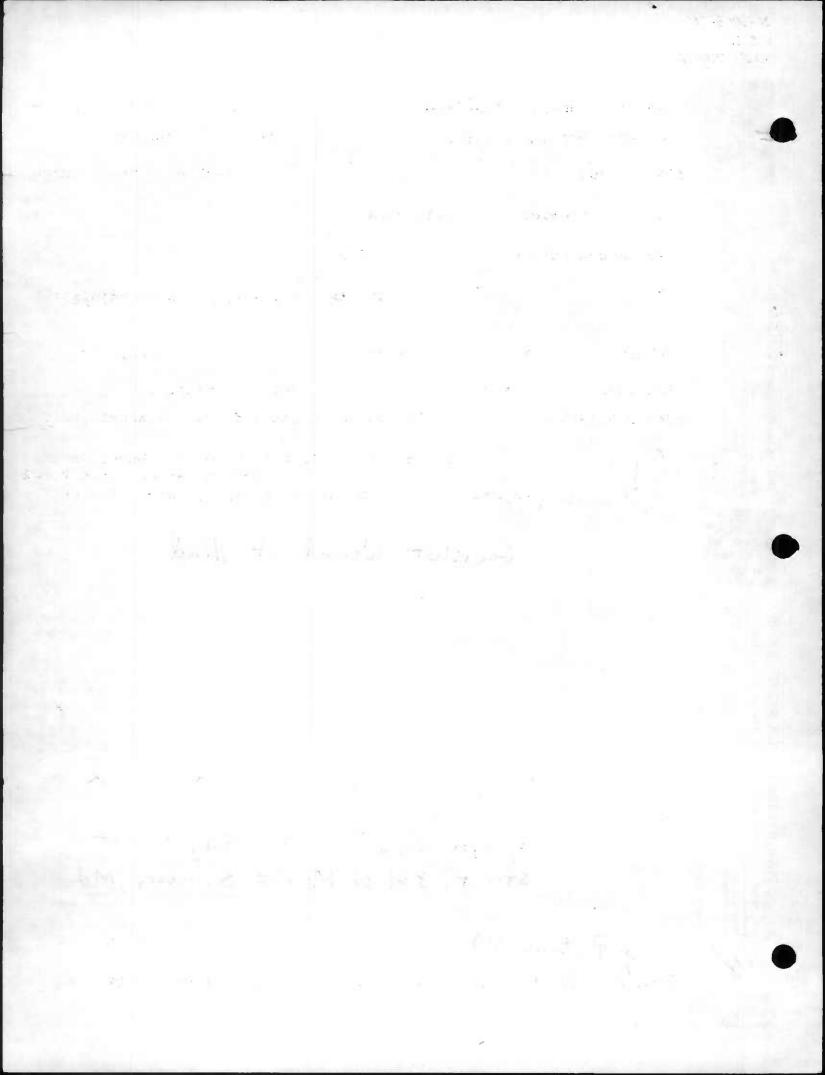


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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-3. Time of Death 2. Data of Deeth 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 29,_ 1998 Angel Morales AUG. 0212 AM /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, giva street end number) 4c. County of Deeth Examiner PENINSULA REGIONAL HOSPITAL SALTSBURY WICOMICO If Under 1 Yaar | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Sociel Security Number 6 Say 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) **Funeral** Days Hours XXM 2DF 31 Yrs. 01-23-67 Director 584-17-1492 Puerto Rico Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours effer death with the Maryland Department of Health and Mental hygiene. Important: If Item 27 is marked other than "nature!! any Injury or other traumetic exceptions." 10a Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits MD Wicomico Salisbury 1 Yes 2 No Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 825 Church Street 21804 USA Funeral 14. Race - American Indian. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 ☐ Yes 2 No If Yes, Give Yeer or Dates: 1 Never Merried 2 Married TX as 2□No Specify: Puerto Rican Specify: Hispanic þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Laborer Laundry Mat Unknown 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be Emiliano Morales Petra Santiago 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) 10 Lowden Street 2nd. Fl. Elizabeth, NJ 07208 Jesus Algarin 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Cementerio Municipal 09-10-98 Yabucoa, PR 22. Name end Address of Fecility Baltimore, Maryland 21202 21. Signature of Funeral Service Licenset 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory errest, shock, or heart failure. List only one cause on each line. WM.C. March FH 1101 E. North Avenue Approximete Interval Between Onsal and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in deeth) Examiner Physician/Medical Examiner Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequence of) the death certificate be exe Box 68760. Dua to (or as a consequence of) for use as P.O. signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown The law requires that by Division of Vital Records, 24b. Were eutopsy findings aveilable prior to Completed 24a. Wes an eutopsy completion of ceusa of deeth? is certificate has director, page 2 1 Yes 2 □ No 1 Yas 2 No Attending Physician: 25. Was case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) YN Yes 2□ No 2 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28e. Dete of Injury Month, Day Year) 28d. Describe how injury occurred 27. Manner of Deeth 28b. Time of Found 28c. Injury et Work? Certification: Afferi 5 Pending 1 Naturel Shot 1253 AMM 1 ☐ Yes 2 No Subj ect 29 98 Investigation death 2 Accident oftar death Director: 281. Location Street and Number or Rural Route Number, City or Town, State)
Salisbury, Md. An 24 hour.
the Funeral Director of filled in by the 6 Could not be determined Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 🛣 Homicide 28e ò 82 Main St. trect . Hospital 29e. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner as stated.

2X Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end menner stated. Medical To the Hosp within 24 ho To the Fune completely fi (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature end title of certifier 29c. License number 29, 1998 O.C.M.E AUG. 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Joseph Per 31. Dete filed (Month, Day, Year) SEP 0 8 1998 restaner 111 Penn Street, Baltimore, Maryland 21201

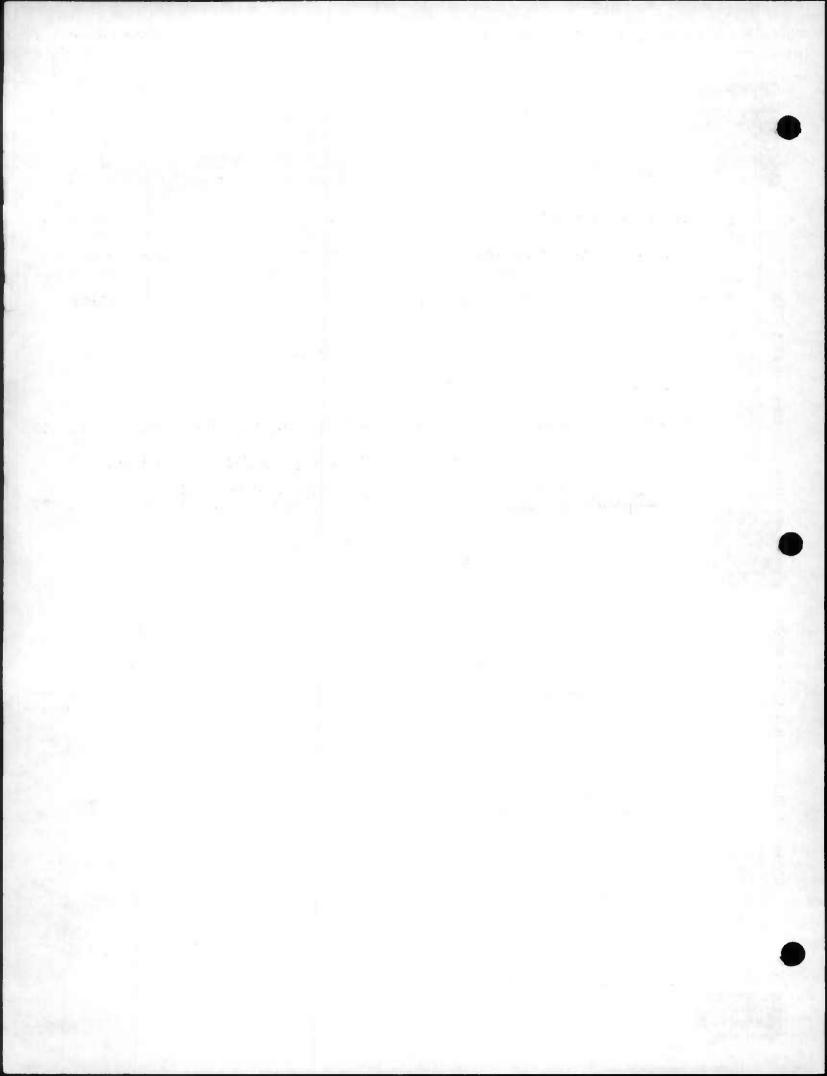
32. Registrer's Signatura



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physicia	an	1. Decedent's Name (First, Middle, Li						Month Day Year			3. Time of Deal	
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la-f ehor	ctor	Maryland Harfo	rd	TOC. CI	y, Town or Location		rdeen			100	1. Inside City Lin 1 ☐ Yes 2 ☐	
3a or 28	al Dire	10e. Street and Number 700 W. Bel Air	Ave., Apt.	327	10	. Zip Code	1001	1	Og. Citizen of V			
al', or items 23a or 28a-f ehow Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2♥️ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armad Forces' 1 X Yes 2 HY Yes, Give Year or Dates:	No No	1□ Y		Hispanic Origin? (Span, Mexican, Puer Specify:	Specify Yes or No- to Rican, atc.)	14. Race Blace Specify	e - America k, White, et		
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ther t		12 17. Fathar's Name (First, Middla, Lasi	iddla, Last)		Taxi Cai		ab Driver 18. Mother's Name (First, Middle		Transportation (to Maiden Summer)			
7 is marked other than traumatic event, tra M	To Be	T 0					Lucy	Harrelson				
Tan I	F	19e. Intorment's Name/Relationship	Type, Print)		T	dress (Stree	t and Number or R	ural Routa Numbe			Code)	
27 ls or tra		Sharon Myles / W:	fe		700 W.	Bel A:	ir Ave.,	Apt. 327	Aberd	leen.	MD 2100	
nt: If item 27 rry or other tr		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - (20c.					City or Tow	n, State			
Important: If any Injury or once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility CAFA Stephen D. Lohrmann P.A.										
	-	8717 Green Pastures Dr., Baltimore, MD 2 23a. Part1. Enter the disease, or complications that causad tha death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximation of the mode of dying, such as cardiac or respiratory arrest, the results of the mode of dying, such as cardiac or respiratory arrest, and the results of the mode of dying, such as cardiac or respiratory arrest, and the results of the mode of dying, such as cardiac or respiratory arrest, and the results of the mode of dying, such as cardiac or respiratory arrest, and the results of the mode of dying, such as cardiac or respiratory arrest, and the results of the mode of dying, such as cardiac or respiratory arrest, and the results of the mode of dying, such as cardiac or respiratory arrest, and the results of the mode of dying, such as cardiac or respiratory arrest, and the results of the mode of dying, such as cardiac or respiratory arrest, and the results of the mode of dying, such as cardiac or respiratory arrest, and the results of the mode of dying, such as cardiac or respiratory arrest, and the results of the mode of dying, such as cardiac or respiratory arrest, and the results of the mode of dying, such as cardiac or respiratory arrest, and the results of the mode of dying, such as cardiac or respiratory arrest, and the results of the mode of dying, and the results of the mode of dying, are results of the mode of dying, and the results of the mode of dying, and the results of the mode of dying, and the results of the mode of dying, and the results of the mode of dying, and the results of the mode of dying, and the results of the mode of dying, and the results of the mode of dying, and the results of the mode of dying, and the results of the mode of dying, and the results of the mode of dying, and the results of the mode of dying, and the results of the mode of dying, and the results of the mode of dying, and the results of the mode of the mode of dying,										
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7 0	Be	25. Was cese refarred to madicel examiner?	Hospital:			0		ath (Check only or	ле)			
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or: After the fune	Certification:	1 Matural 5 Pending 2 Accident Invastigatio 3 Suicide 6 Could not b	(Month, Da	y Year)	Injury M	28c. tnju Wo 1	ury at ork? 28d. Describe how Injury occurred ork? □ Yes 2 □ No					
To the Funeral Director: After completely filled in by the funer	Certifi	4 Homicide determined		jury - At he c. (Specif	ome, farm, street, fa	ctory, office	2	28t. Location (Street and Number or Rural Route Number, City or Town, State)				
letely,	edical	29a. Certifier 1 ✓ Certifying Pt (Check only one) 2 ☐ Medical Example 1	ysician: To the best ntner: On the besis o and manner st	f examina	wiedge, deeth occu tion and/or investiga	rred et the ti atlon, in my o	me, dete and place opinion, deeth occu	e, and due to the curred at the time, d	ause(s) and ma late end plece, a	nner as sta and due to t	ted. he cause(s)	
20	Me	29b. Signature and titla of certifier				29c. Lican	se number	2	9d. Date signed	d (Month, D	ay, Year)	
Som Som	- 1	1501-16	29b. Signature and titla of certifier 29c. Licanse									
Com												
Com		30. Name and address of person who	completed ceuse of o				Maryland		oq oquas			

DHMH 16 Rev 6/95



WRC 98-5073-510 JERALD MICHAEL

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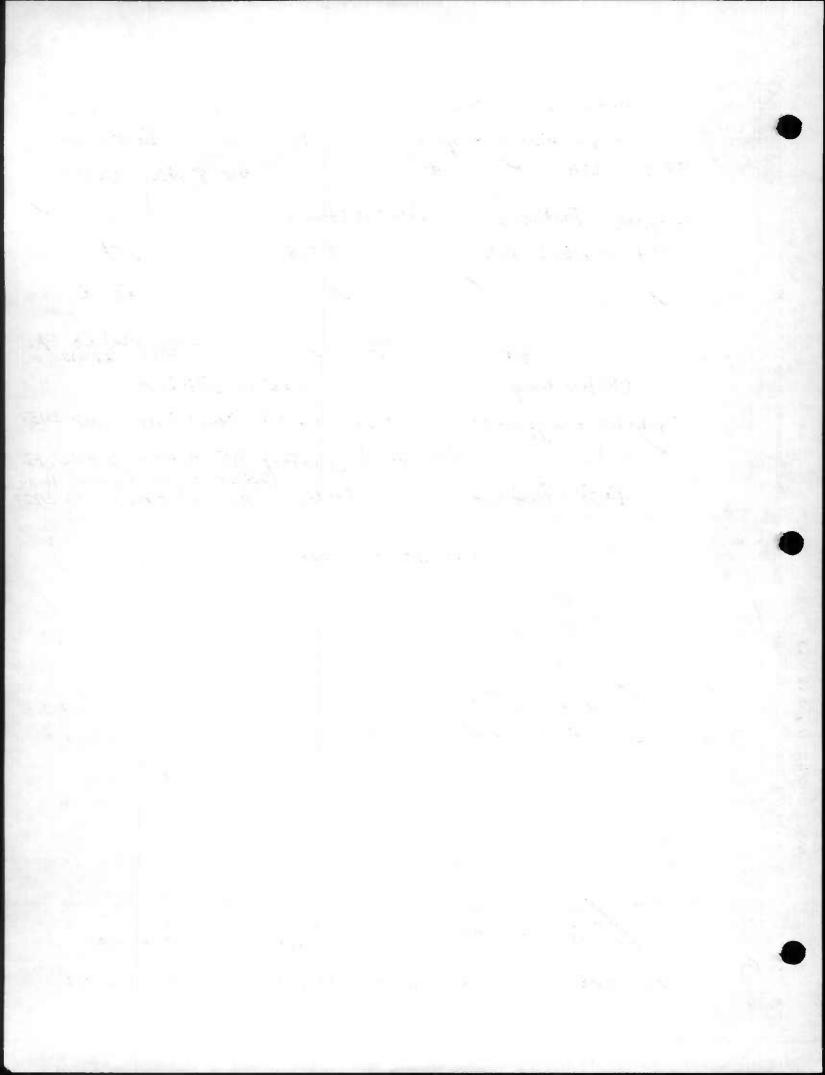
State of Maryland / Department of Health and Mental Hygiene

McFALL			oraro or maryrar		ate of Death	B	eg. No.	2/3	12				
- Physici	an	Decedent's Neme (First, Middle, La	ist)		2. Dete of Dee	th	Veer	me of Deeth					
/Medic	al	Gerald Mich	4h City Town or	AUGUST	27, 199		20 PM.						
Examin	er	4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth JOHNS HOPKINS HOSPITAL BALTIMORE											
Funeral Director		5. Social Security Number 6. 5	Sex/ 7. Age (In yrs.		er 1 Year If Under 24 Hrs Buys Hours Mir	s. 8. Dete of Birth	Year) 58	9. Birthplece (St. Country)	tete or Foreign				
D N N		Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City											
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15-C	letec	15. Decedent's E (Specify only highest gro	ducation ade com <i>pleted)</i>	16e. Decedent's U	suel Occupetion work done during most of we use retired)	orking	16b. Kind of Bu	Siness/Industry					
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nd illing other	Be Co	17. Fether's Neme (First, Middle, Last)	Cilia	18. Mother's Na	ama (First, Middle,	Maldan Sumem	9)	431 (43)				
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other other		20e. Method of Disposition	20b.	Plece of Disposition (A	ledera of rother place)	Date	20c. Location -	City or Town, Ste	te				
altimore, mit. Pages 1 s pertment of His portant: If Nam y Injury or othe	8	1 Buriel 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Special		Voschell	Cemetery	9-10-98	Deltin	ve Mar	uland				
Ball Separation mood my injury		21. Signeture of Funeral Sarvice Lice	nsee	22. Nama	end Address of Fecility	renal How	re & Ser	vices	7				
- 45210		23a. Pent. Enjective disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate thiervel Between Onset end Deeth											
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/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) e. Multiple Gunshet wounds Due to (or es e consequenca of):											
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guted d ansit	Examiner	Sequentially list conditions	b. Due to (or as e consequenca o	vf):			i					
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Division To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fur	Ž	29b. Signatura and title of certifier			29c. Licensa number			d (Month, Dey, Yo					
,		Aliph 10	A Vlac	LZ MP	O.C.M.E.		AUGUST	28, 1998	}				
1	-	30. Name and address of person who	•		reet, Baltim	ore, Marv	land 21	201					
Sta	ite	31. Dete filed (Month, Day, Year)	adent2, 1 32. Registrer's Sign										
Doniel	0.0	SEP 0 8 10	00		/								

Registrar

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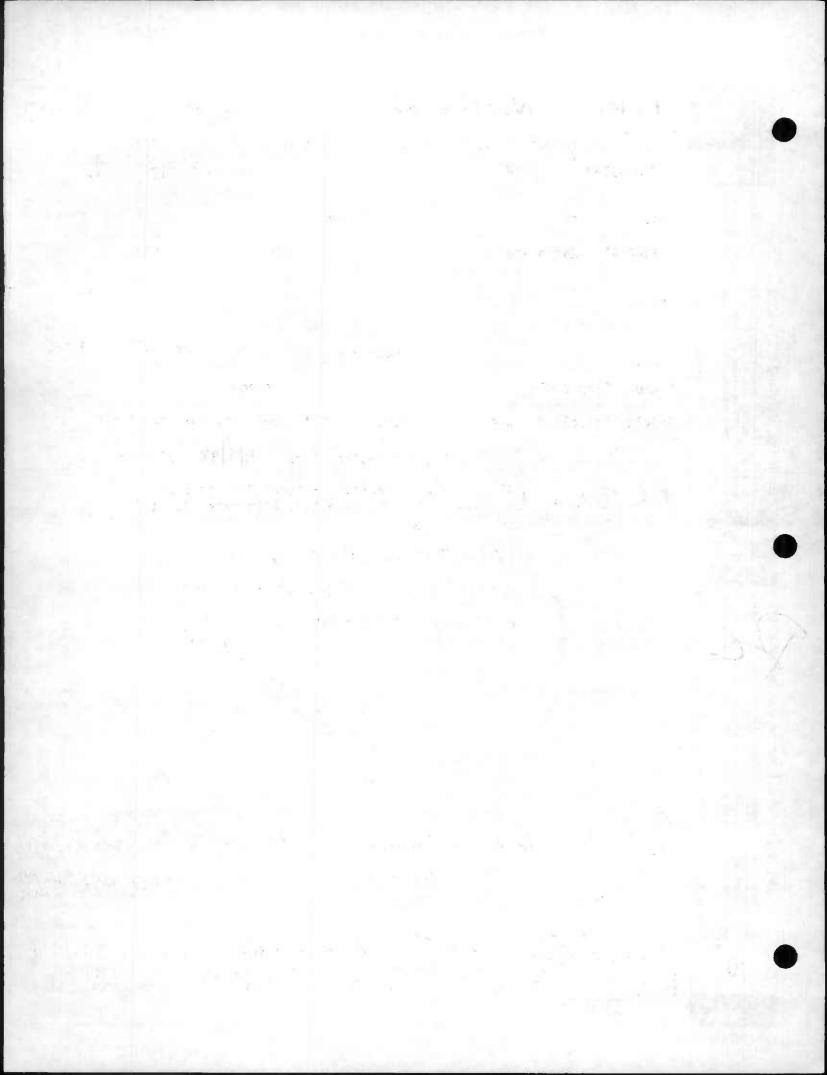


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month Day **Physician** lember elen Nor ۵ /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Name (If not institution, give street end num Examiner Hunder 24 Hrs. 8. De 121 141 8. Dete of Birth (Month, Dey, Year) 9. Birthplace (State or Foreign Country) If Under 1 Year 5. Sociel Security Number 8. Sex 7. Age (In yrs. lest birthday) **Funeral** Min. 1 M 2 XF 86 Months Deys Hours 173-03-2593 March14,1912 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10e Stete 10b. County 10d. Inside City Limits 7 is marked other than "natural", or itema 23a or 28a-f show traumatic event, tre Medical Examiner must be notified at XYes 2 □ No Director Baltimore Md. n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1602 Glen Eagle Road 21239 USA death Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-it Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American indien, 11. Maritel Status Bleck, White, etc. 72 hours after 1 Never Merried 2 ☐ Married specify: White Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Š 3 Ø Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) of filed within 7 lal Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Max Waller Oil Co. Bookkeeper 10th permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 is marked othe any injury or other traumatic event, page. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Emuel Clapsaddle unknown 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. informant's Name/Relationship (Type, Print) P.O. Box 1384 Ocean View Delaware 19970 Shirley Dattoli / daughter 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2X Cremetion 3 ☐ Removel from State 8 98 Metro Crematory Inc. Baltimore Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Fecility 21. Signature of Funeral Service Licensee Connelly Funeral Home of Essex onn 300 Mace Ave. Baltimore MD. 21221 there the mode of dying, such as cardiec or respiretory arrest. 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical immediate Cause (Final nonia Secondary diseese or condition resulting in death) Examiner Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical thet initiated events resulting in death) Lest Part II. Other significant conditions contributing to death but not resulting in the unded vino gauss given in fluid 23b. Did tobacco use contribute to the cause of death? SECRETH AN Records, P.O. 8 signed by to Probably 4 Unknown 1 ☐ Yes 2 ☐ No þ 24b. Were eutopsy findings evailable prior to completion of cause of death? 24e. Wes an autopsy Completed # page 2 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No certificate Division of Vital 88 25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify), Injury at 28d, Describe how injury occurred both of the following of the examiner? 12 Yes 2 No 10 1 Appatient 2 ER/Outpetient 3 DOA After this 28d, Describe how injury occurred for the form of Steps after being seen at up of steps 28t. Location (Street end Number or Rurel Route Number, City or Town, Stete) funeral Certification: 28c. Injury at Work? 27. Manner of Deeth 28b. Time of 28e. Date of Injury (Month, Dey Year) Athending 5 Pending 1 Natural 1 ☐ Yes 2 No 2 Accident Fall duristers investigation 14547 30,1998 after dealt Director: 6 Could not be determined 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1602 Golen Egsle RD, Byltono, MC To the Hospital of within 24 hours a To the Funeral D nome 2/200 Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated. 29e. Certifier Medical 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete and piece, and due to the cause(s) end menner stated. (Check only one) 29d. Date signed (Month. Dev. Year) 29c. License number 29b. Signature and title of cartifie pleted cause of death (item 23e) (Type, Print)

32. Registrer's Signeture

MAN

State



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nema (First, Middla, Last) 3. Time of Deeth 2. Date of Deeth Month Day Yas September 2, 1998 12:50A Louise Jarvis 4b. City. Town, or Location of Deeth 4a Fecility Nema (If not institution, give street and number) 4c. County of Deeth Gilchrist Center Towson Baltimore 5. Social Security Number if Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) March 24, 1929 Birthplece (State or Foraign Country) 7. Age (In yrs. last birthday) 10 M 27X Months Days Hours Min Yrs. 213-30-0911 69 Maryland Usuei Residence of Decedent 10d. fnside City Limits 10h County 10c. City. Town or Location 1 ☐ Yes 2 ☐ No Maryland Baltimore Towson 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 1500 Boyce Avenue 21204 USA 12. Was Dacedant Ever in U,S. Armed Forces? 1 ☐ Yes 22 0 No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11. Maritai Status Black, White, etc. 1 Navar Married 2 Married 1 ☐ Yas XX No Specify: Specify: White 3XXWidowed 4 ☐ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Eiamentery/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) Charles Lloyd Claypoole Elizabeth Nottingham 19b. Malling Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) 19e. informent's Neme/Reletionship (Type, Print) Elizabeth King DTR 812 Kellogg Road Lutherville, Maryland 21093 20b. Piece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burial &Cremetion 3 Removel from Stete 9/3/98 Greenmount Cemetery Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Fecility Consture of Funeral Seryice Licenses Mitchell-Wiedefeld Home Inc. 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart tailure. List only one ceuse on each line. Approximete Intervei Batween Onset end Death Immediate Cause (Final disaesa or condition resulting in deeth) lung Concer one year Due to (or es e consequence of) Sequentielly list conditions, if any, laading to immediate cause. Enter Underlying Ceuse (Diseese or injury that Initieted events rasulting in deeth) Lest Due to (or es e consequence of) Due to (or as e consequence of) 23b. Dfd tobacco usa contribute to the cause of death? Part II. Other aignificant conditions contributing to deeth but not resulting in the underlying cause given in Pert i. 1 Yee 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings aveilebie prior to 24e. Wes en eutopsy periormed? completion of causa of death? 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 28e. Dete of Injury (Month, Dey Year) 28d. Describe how Injury occurred 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 5 Pending Investigation Naturel 2 Accident

Physician /Medical Examiner Septemben - 2

Physician/Medical Examiner physician 2 by Completed Be P

Physician

/Medical

Examiner

Funeral

Director

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Examiner must be n

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should be filed within 72 hours after deeth and Mentel Hygiene.

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permit. Pages 1 and 2 sh Department of Health end Important: If then 27 Is m any injury or other traum onds.

Baltimore, Maryland 21215-0020

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Directo

Funeral

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Completed

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law requires that the death certificete be this certificate or Attending Physician: After this Director: 24 hours

Division of Vital Records, P.O. Box 68760,

DRR JANVIS

within 2

State Registrar

Certification:

edicai

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifie

uns

28e. Piece of injury - At home, ferm, street, fectory, office building, etc. (Specify)

29c. Licanse number

1 ☐ Yes 2 ☐ No

1 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner as steted.
2 Madical Examinar: On the bests of examination end/or investigetion, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) end manner steted. 29d. Data signad (Month, Dey, Year) fenler 2, 1998

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

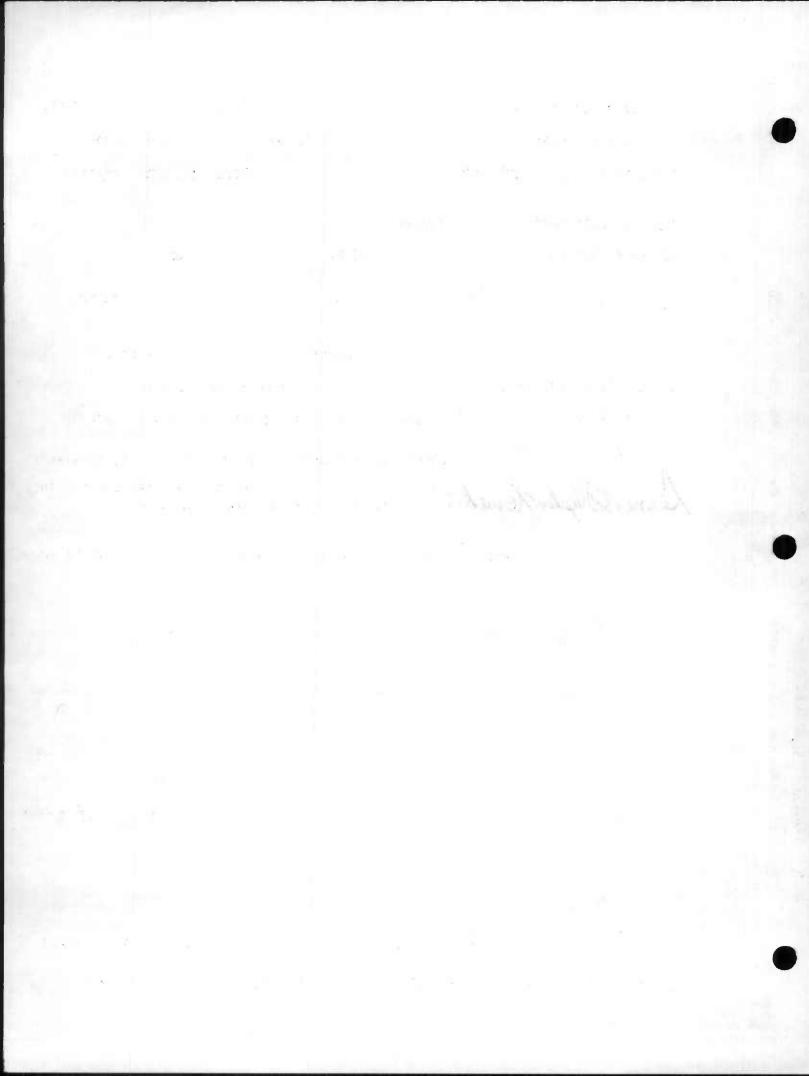
30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

N. Chale St. Balto. Md 2,205 GBMC A. Riley 6701

31. Dete filed (Month, Day, Year) SEP 0 8 1998

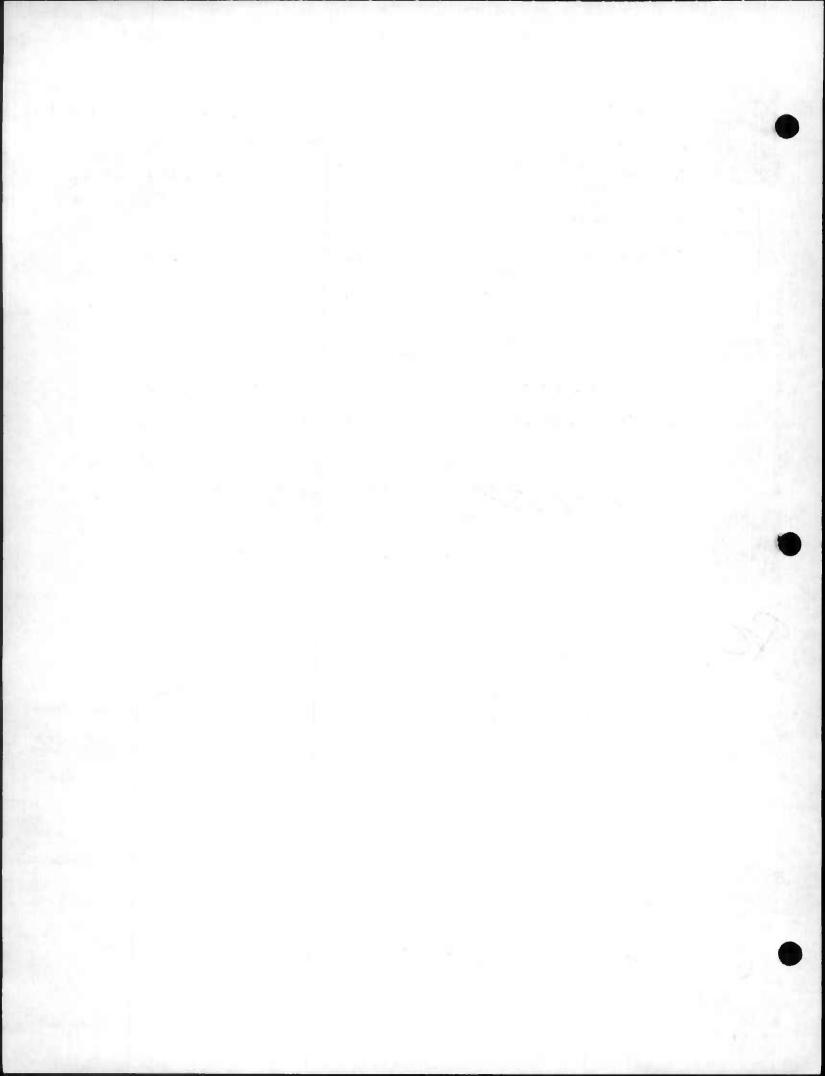
6 Could not be determined

32. Registrer's Signature Ener



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	Decedant's Nama (First, Middla, L.)	ast)	C	ertificate of	Death	2. Data of D	Reg. No.	3.1	ima of Death
sician	EUNA MAE PURVIS					Month	Day	Yaar	
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or .	267-46-4711 Usual Rasidance of Dacedant	A COLA ORDINE	9 Yrs.	Months Days	Hours Mi	April	26,1909	9. Birthplaca (S Country) George	a
_	10a. Stata 10b. County		10c. City, Town or	Location					sida City Limits
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Dire	10e. Street and Number			10f. Zip Coda			10g. Citizan of V	Vhat Country?	
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by Funerai		12. Was Decedant Armed Forcas? 1 ☐ Yas 2 🔯 If Yas, Giva Yaar or Datas:		3. Was Dacedant of H If Yas, specify Cub 1 ☐ Yas 2 ☑ No		Specify Yas or N irto Rican, atc.)	o- 14. Race Blace Specify	e - Amaricen Ind k, Whita, atc. White	ian,
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	21. Signatura of Funaral Sarvice Lice	nsaa		22. Nama and Addre	ass of Facility	11	Dan Ata	7 .	
5	11/1			Schimunek 610 W. Mac	Phail P	Home of	Bel Aur	D. 210	1 1
	23a. Part1. Enter the disease, or co shock, or haart failura. List onl	nplications that cause	d the death. Do not a	ntar tha moda of dyl	ng, such as cardi	ac or raspiratory	arrast,	Appro	oximata ai Batwaan
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Certification:	3 Suicida 6 Could not 4 HomicIde detarmine	28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify)				28f. Location (Straet and Number or Rural Route Number City or Town, State)			
edicai	29a. Certifiar 12 Gertifying F (Check only one)	hyalcian: To the best minar: On the basis o and mannar st	f examination and/or	ath occurrad at tha ti invastigation, in my o	ma, date and place opinion, death oc	e, and due to the curred at the time	cause(s) and ma , data and place, a	nner as stated. and dua to tha ca	ausa(s)
Z e	29b. Signatura and titla of certifiar			29c, Licans	sa number		29d. Data signed	(Month, Day, Y	'ear)
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tate	31. Data filed (Month, Day, Year)		ar's Signatura	lan 11		,			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month 4b. City, Town, or Location of Deeth 4c. County of Flants Razmus Andrew 0811 4a. Fecility Neme (If not institution, give street end number) Johns Hopkins Bayview Medical Center Douttmore 1/2 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthdey) If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) Aug. 30,1914 Birthplece (State or Foreign Country) 10b. County 10c. City, Town or Location 10d. fnside City Limits BALTIMORE 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 3305 DONNELL 13. Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 0.5. 57. 12. Was Decedent Ever in U,S. Armed Forces? 1 Myes 2 □ No If Yes, Give Year or Detes: Rece - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1□ Yes 2No Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MACHINIST 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) BONK JOSEPH JULIA 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) NAOMI RAZMUS 3305 0 DONNELL ST. BALTO. MD. 21224 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State Dete Burial 2 Cremetion 3 Removei from State 4 ☐ Donetion 5 ☐ Other (Specify) BALTO. CO. HD. 21. Signature of Funeral Service Licensee 22. Name end Address of Facility 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death Immediate Cause (Final Cardiac disease or condition resulting in deeth) minutes failure renal Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Lest cardiomyopathy schemic Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown sick sinus syndrome, hypertension 24b. Were eutopsy findings evelleble prior to completion of cause of death? 24e. Was en eutopsy performed? chronic renal insufficiency, 1 ☐ Yes 2 ☐ No

Physician /Medical **Examiner**

Department of Health er Important: If item 27 is any injury or other trau

Physician

/Medical

Examiner

10e. Stete

Director

Completed by Funeral

Be

Funeral Director

flours to many and matural, or items 23s or 28s-f show marked other than "natural, or items 23s or 28s-f show martic event, the Medical Examines must be notified at

Peges 1 and 2 should be filed within 72 hours efter death with and of Healing Hygiene.

Interest of Healing T is marked other than "natural", or items 23a or ury or other traumatic event, its Moutain Example man by ury or other traumatic event, its Moutain Example.

21215-0020

Baltimore, Maryland

or Attending Physician: The lew requires that the death certificate be specuted certificate

Examiner After death. 24 hours efter death Funeral Director: in by the

Division of Vital Records, P.O. Box 68760,

Be Completed by Physician/Medical

Certification: To

29a. Certifier (Check only one)

SEP

25. Wes case referred to medical exeminer?

1 Yes 2 No

27. Magner of Death

1 Natural

2 ☐ Accident

3 Sulcide

4 Homicide

5 Pending investigation 6 Could not be determined

Hospitel: 12 Inpatient 2 ER/Outpetient 3 DOA

28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No

28c. fnjury et Work?

28d. Describe how injury occurred

26. Piece of Death (Check only one)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) Certifying Phyeician: To the best of my knowledge, death occurred et the time, date and plece, and due to the ceuse(s) end manner es steted.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end pleca, and due to the cause(s) end manner stated.

D. Wans MD

29d. Date signed (Month, Dey, Year) September 6 1998

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

31. Dete filed (Month, Day, Year)

32. Registrer's Signature

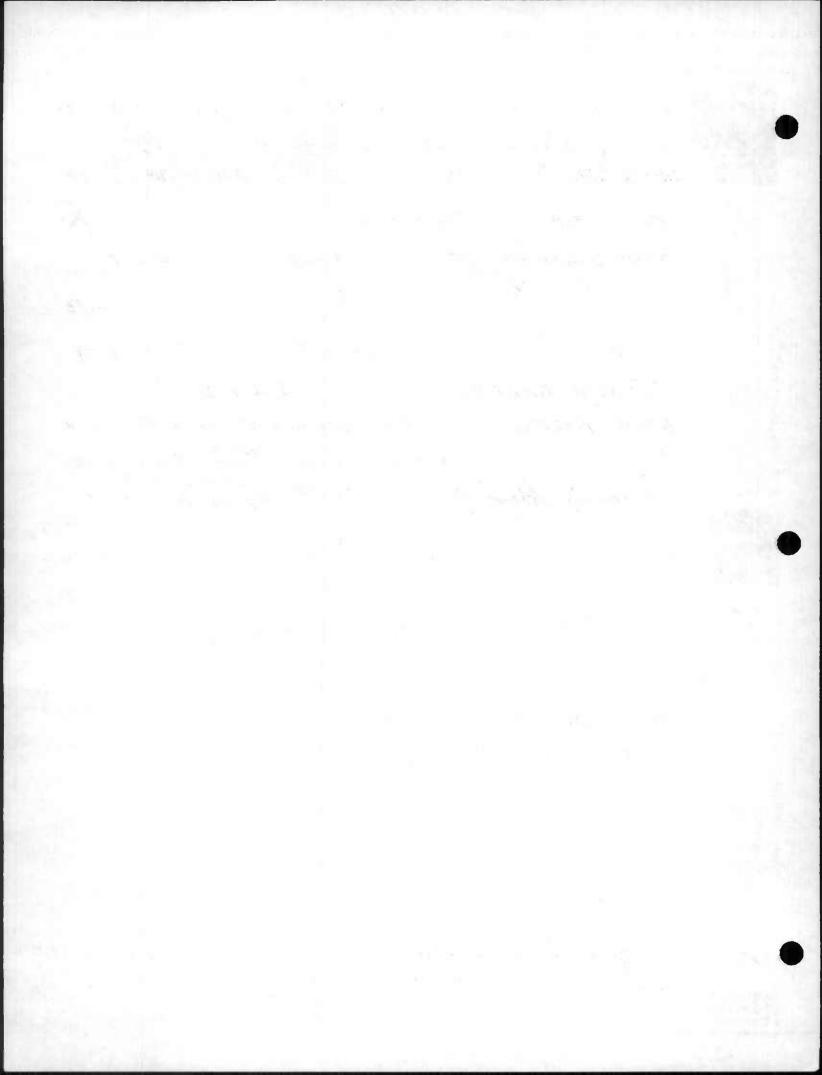
Baltimore Maryland 21224

State Registrar

Medicai

Hospital

To the within 2



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 2. Data of Deeth 3. Time of Death Dev Month Yaar Physician SEIN HOLDS AROLINE SEPTEMBER 6, 1998 05:22A · /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Fecility Nama (If not institution, give street and number) Examiner ST. AGNES HEALTH CARE BALTIMORE 9. Birthpleca (Stata or Foreign Country) If Undar 1 Yaar Months Days If Undar 24 Hrs Hours Min. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Aga (In vrs. last birthday) 6. Sax **Funeral** 1□M 2 F 155-03-8749 Yrs. OCT. 11,1920 Director Usual Rasidance of Dacedant 10a. Stata 10c. City, Town or Location 10d. Inside City Limits 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Expressor mant be notified at 1 Yas 2 No BALTIMORE Directo MD 10g. Citizan of What Country? 10e Street and Number 10f. Zip Code 21229 U-5.A 3330 KENS Funeral 13. Wes Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Ricen, atc.) 12. Was Decedant Evar in U,S Armed Forcas? 14. Race - American Indian, Black, Whita, atc. 11. Maritel Status Pages 1 and 2 should be filed within 72 hours after on the filed within 72 hours after one of Health and Mental Hygiene. At: If Item 27 is marked other than "natural", or item 1 ☐ Yas 2 No 1 Naver Married 2 Married 1 ☐ Yas 2 No Specify: Specify: WHITE PV 3 ☐ Widowed 4 Divorced Year or Dates Completed 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Dacedant's Education (Specify only highast grada completed) Elamantary/Secondary (0-12) Collega (1-4or 5+) DWN, HOME MAKER 17. Fathar's Nema (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) UNKNOWN ERNEST MARGALET ENGELDER 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rurel Routa Number, City or Town, Stete, Zip Coda) MS. DORSEV Towson MD. 21204 DEPT. OF AGINC 6/1 LENTRAL AVE other t 20b. Place of Disposition (Name of cematary, cramatory or other place) Data 20c. Location - City or Town, Stata 20a. Mathod of Disposition Burial 2 Cramation 3 Ramovel from State 4 Donation 5 Othar (Specify) 00 permit. Page Department of Important: If any Injury or pace. 1998 BALTO. CO. CEM AWN 22. Nama and Addrass of Facility 21. Signature of Funeral Service Licensee 2829 HUDSONST SKARDA BALTO. 23a. Part1. Enter the disease of complications that caused the deeth. Do not anter the mode of dying, such as cerdiac or respiratory errest shock, or heart failure. List only one cause on each line. Approximate Intarval Batween Onset end Daeth **Physician** /Medical Immediate Cause (Final o na diseasa or conditio rasulting in daath) Examiner Sequantially list conditions, if any, laading to immadiata ceusa. Entar Undarlying Ceuse (Diseese or Injury that initiated events rasulting in daath) Last Dua to (or as a consequence of): edical Due to (or as a consequance of): Physician/M 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceusa given in Part I. 3 Probably Unknown 1 Yes 2 No à 24b. Wara autopsy findings available prior to completion of cause 24a. Was en eutopsy Completed page 2 s 1 Yas 1 ☐ Yes 2 ☐ No 25. Was cesa refarrad to medical examiner? 86 26. Placa of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 10 1 Inpatiant 2 ER/Outpatient 3□ DOA 1 Yas 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 28a. Data of Injury (Month, Day Year) Certification: 1 Natural 2 Accident 5 Panding 1 Yas 2 No invastigation 6 Could not be datermined 3 Sulcide 28a. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 4 Homicida Certifying Physician: To the best of my knowledga, daath occurred at the tima, date end place, and dua to the cause(s) and mannar es steted. 2 Medical Examiner: On tha basis of examinetion and/or invastigation, in my opinion, death occurred et the tima, data end place, and due to the ceusa(s) and mannar statad. 29a. Cartifiar Medical (Check only one) within 2 To the F

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death

Baltimore, Maryland 21215-0020

of Vital Records, P.O. Box 68760.

and line Rentields

State Registrar 31. Data filad (Month, Day, Yaar) 32. Registrar's Signatura 08 1998 SEP

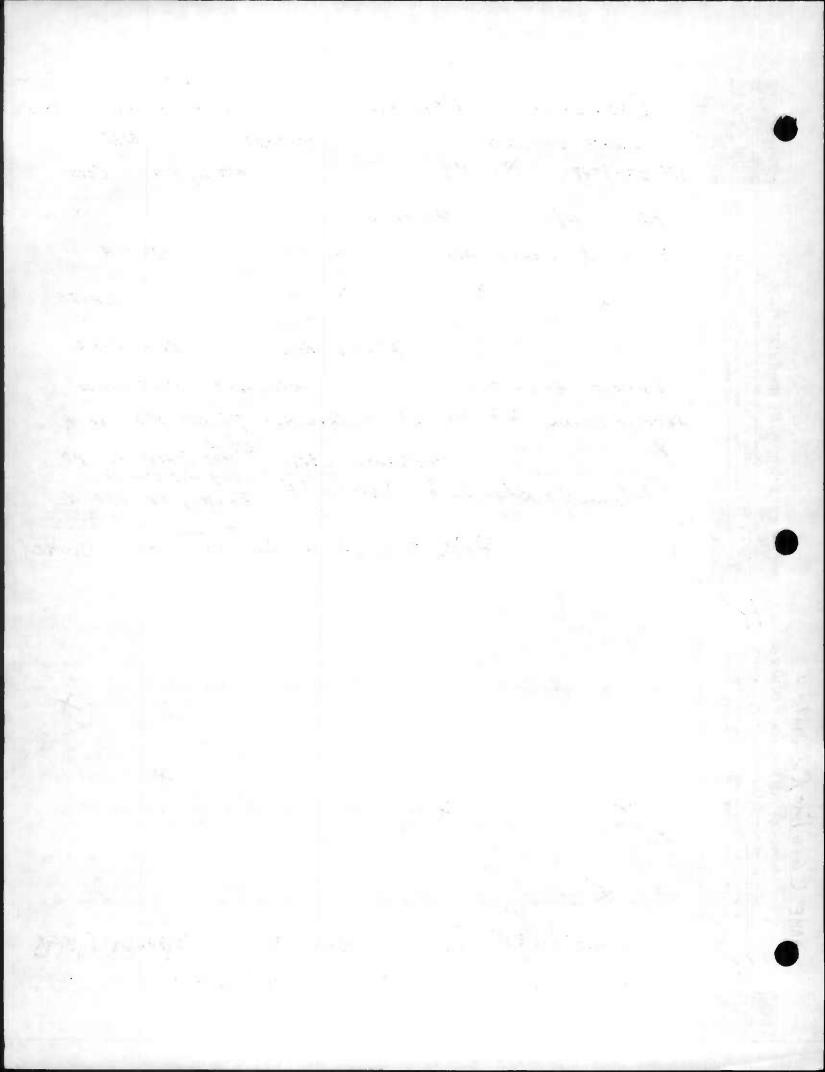
29b. Signatura and titla of certifian

30. Neme end eddress of person, who co

29c. License numbar

29d. Data signed (Month, Dey, Yaar)

d causa of daeth (Item 23a) (Type, Print) ST. Aguex 900 Grow Ave, Hospital,

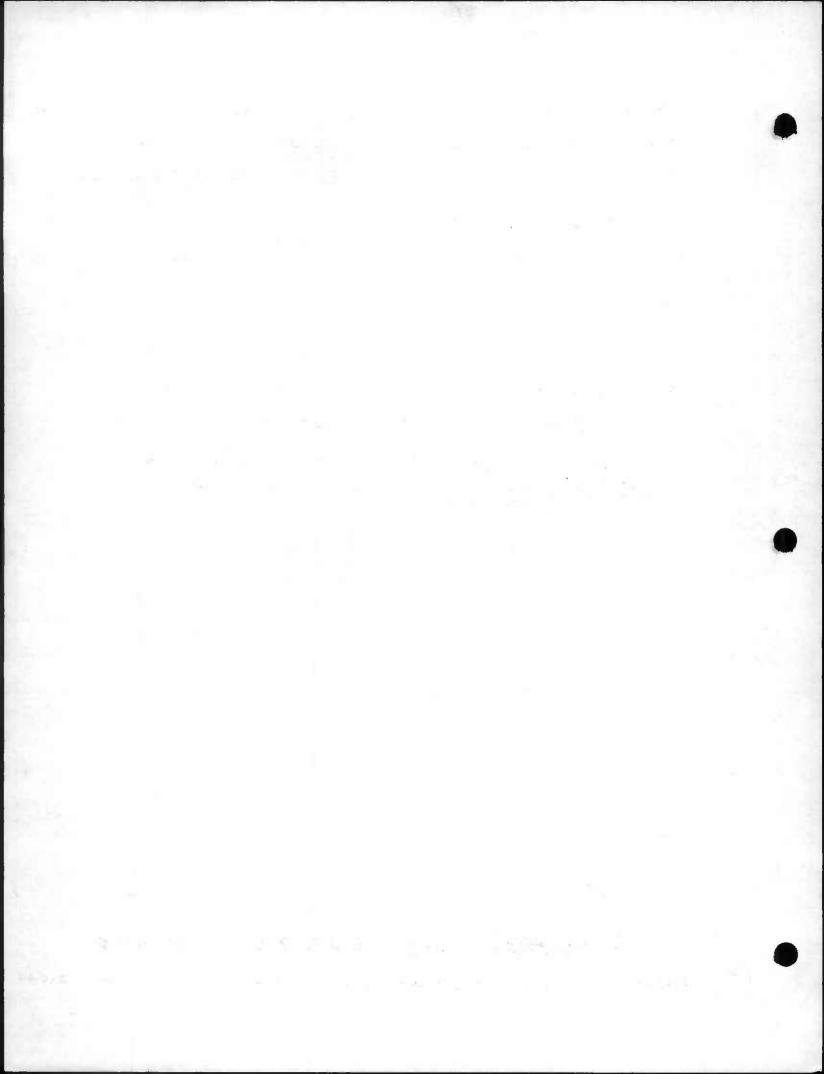


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State of Maryland / Department of Health and Mental Hygiene

								rtificate		Death		Reg. No.	273	19
	Physici	an	Decedent'a Name (First, Middle, Last)						2. Dai		ith Day Yes	3. Time of Death		
	/Medi		Frances M. Rogers								Sept. 1	1998		00am
	Examir	ner	4a. Feclity Neme (If not Inst							lb. City, Town, or L		4c. County of De		
			Colonial Ma		The same of the sa			If Under 1		Catonsvil		Baltimo		
	Funeral Director		5. Social Security Number 220–24–4318 Usual Residence of Decade		M 2ØF	. Age (In yrs.	. last birthdey) Yrs.		Deys	Hours Min.	8. Date of Birtl (Month, Day June 13	, Year) 9. E , 1910 Mai	Birthplace (State Country) ryland	e or Foreign
	farylend stary	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Howard Fulton									10d. Inside	City Limits	
	the N	Director	Maryland How	ard		Fu	Iton	10f. Zip C	ada.			10g. Citizen of What		
	with with				D 3								Country	
	eath re 23	era	12343 Scaggs	viite	12. Wes Deced	lent Ever in I	JS 13		759	ispanic Origin? (Sp	ecify Vee or No-	U.S.A.	merican Indian.	
21215-0020	72 hours effer death with the Maryland "naturel", or items 23a or 28a-f show idipal Examinet must be notified at	by Funeral	1 ☐ Never Married 2☐ 3 ☑ Widowed 4 ☐ Div		Armed Ford 1 Yes 2 it Yes, Give Yeer or De	ces? ⊇ŽiNo		it Yes, specify		t of Hispanic Origin? (Specify Yes or N Cuban, Mexicen, Puerto Rican, etc.) No Specify:		Specify:		
5-0	72 ho	Completed	15. Dec	edent's Ed	ducation ide completed)		16e. Dece	dent's Usuel (Occupi	etion	ina	16b. Kind of Busine	ss/Industry	
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	filed with Hygiene. ther than	5	7 Soil Conservationist							Agricultu	re			
pu	d a b	Be	17. Father's Name (First, Mi	ddle, Last)								Maiden Sumame)		
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Maryland	C/ 00 T 18		19a. informant's Name/Rela									r, City or Town, State		
	s 1 and f Health frem 27 other tr		Gary Rogers	(Gran	dson)	- I a see						ryland 21		
0	S 0 1 1		20a. Method of Disposition 1 ☑ Burial 2 ☐ Crema	tion 3 🗆	Removal from S	20b.	Place of Dispo cemetery, cre	metory or other	e of er piec		Dete	20c. Location - City	or Town, Stete	
Ë			4 □ Donation 5 □ Oth	er (Specif	y)		. Zion					Fulton, M		
Baltimore,	Departm Importa any Inju		21. Signature of Funeral Service Licensee 22. Name end Address of Facility Witzke Funeral Homes, Inc.										, Inc.	
_	00540		5555 Twin Knolls Rd. Columbia, MD 21045											
			23a. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dylng, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death											Between
	Physician		immediate Cause (Fine)											
1	/Medical Examiner		immediate Cause (Finei disease or condition resulting in death) a. UNGESTIVE HEART FAILURE									6 N	LOWEIT	
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	outed nd transit	Examiner	HYPERTENSION										101	EMICS
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œ-	3 19		Cause (Disease or injury that initiated events						10				- 0 "	
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ds,	8 5 8	d by									Die Wee	24	b. Were autops	y findings
Record	been si should	Completed									24a. Was a	med?	completion of	or to
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of Vital	Physician: this certific ral director,	Be C	25. Was cese referred to me examiner?	dicel	Hospital:				Othe	26. Piace of Deet er:		-	ACEIS	769
	Phys rald	: To	1 Yes 2 No 27. Manner of Death		1 ∐ In		28b. Time of			4 LI Nursing Ho		ence 6 Dother (S	pecify) LCV	124
Division	ding h. After	tlon	1 Naturai 5 □ P	ending vestigation	(Month	, Dey Year)	injury	м	c. Injun Work	k? Yes 2 □ No		,,		
S	Attending in death. Sector: After by the fune	Certification:	3 ☐ Suicide 6 ☐ C	ould not be		of injury - At h	ome, tarm, str	eet, factory, o			28f. Location (S	treet and Number or	Rural Route N	umber,
S	affer Dire	ert	4 ☐ Homicide	20111111100		g, etc. (Speci		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			City or Tow	m, State)		
	Hospital 24 hours a Funerel Cletely filled		29a. Certifier 1D Cer	tifying Ph	ysician: To the b	est of my kno	owiedge, deati	n occurred at	the tim	ne, dete and place,	and due to the o	ause(s) and manner	as stated.	
	To the Hospital or Attending Phywithin Zyden death. To the Funerel Director: After thicompletely filled in by the funeral completely filled in by the funeral	edical	(Check only 2 Med one)	lical Exam	niner: On the bas and manne	is of examina	ation end/or in	vestigation, in	n my op	plnion, death occur	red at the time, o	date end piece, and c	lue to the cause	B(S)
	To the Within 2 To the comple	Me	29b. Signature and title of ce	ortifier					1111	e number		29d. Date signed (Mo	onth, Day, Year)
			1	2	Edo.	. 4	M.D	D	4	3772		09/04/	98	
	12		30. Name and address ot pe	rson who	completed ceuse	of death (ite	m 23a) (Type,	Print)						
_	10		RASAR AB						LE	ROAD, +	200A, C	CLUMBIA	MD "	21044
	Sta	_	31. Date filed (Month, Day,	rear)		gistrar's Sign	ature				-			

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician BETTY** ROWE SEPTEMBER 6 1998 18:11 /Medical 4a Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY If I Inder 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Months Hours 10M 20F Director 213-28-3548 69 Maryland Usual Residence of Decedent death with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d Inside City Limits "natural", or flems 23s or 25s-f ahow edical Examiner must be notfled at 1 Yes 2 No Director Maryland | Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 U.S.A. 1910 Lismore Lane Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ŽŌXNo If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11 Maritel Status Bleck, White, etc. filed within 72 hours after 1 Never Merried 2 Married 21215-0020 1 ☐ Yes 21 No Specify: þ Specify: 3 Widowed 4 Divorced White Year or Detes: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental hygient Important: If fem 27 is marked other that any fulury or other traumatic event, that pages. Home Maker Own Home 12 Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Thomas P. Matthews Katherine Dean 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Dr. James E. Rowe (Husband 1910 Lismore Lane Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burlal 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral Cemetery 9/10/1998 Baltimore, MD 22. Name and Address of Fecility Witzke Funeral Homes, Inc. 21. Signature of Funeral Service Licensee 1630 Formandson Ave. Catansville, MD 21228 23a. Part1. Enter the disease, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) ANOXIC ENCEPHALOPATHY Examiner Due to (or es a consequence of): Examiner ician end burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): P.O. Box 68760. edicai Due to (or as e consequence of): Physician/M The lew requires that the death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, þ 24b. Were autopsy findings evailable prior to completion of cause of deeth? Completed 24a. Was en autopsy performed? page 2 has 1□ Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: funeral director. 25. Was case referred to medical examiner? Be 26. Place of Daeth (Check only one) examiner/ Hospital: 2☐ER/Outpatient 3☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To After this 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Neturel 2 Accident 1 ☐ Yes 2 ☐ No deeth after deeth Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) within 24 hours after de To the Funeral Directo completely filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Phyalcian: To the best of my knowledge, death occurred et the time, date and place, and due to the ceuse(s) end manner as stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) g g 29b. Signature and title of contiller 29c. License number 29d. Date signed (Month, Dey, Year) 2 9/6/98 P1930

HO State

Registrar

31. Date filed (Month, Dey, Year) SEP 0 8 1998

AJAY JAIN

32. Registrar's Signeture

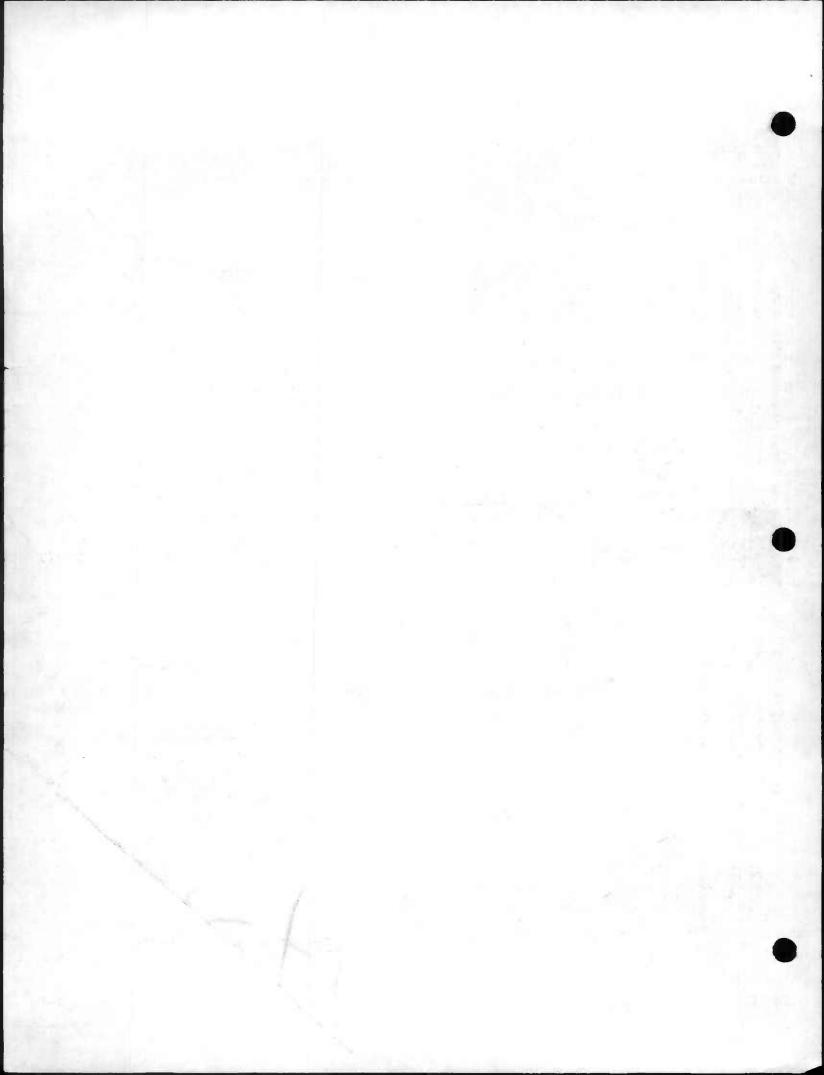
101 EAST MOUNT ROYAL AVE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

APT 307

BALTIMORE, MD 21202

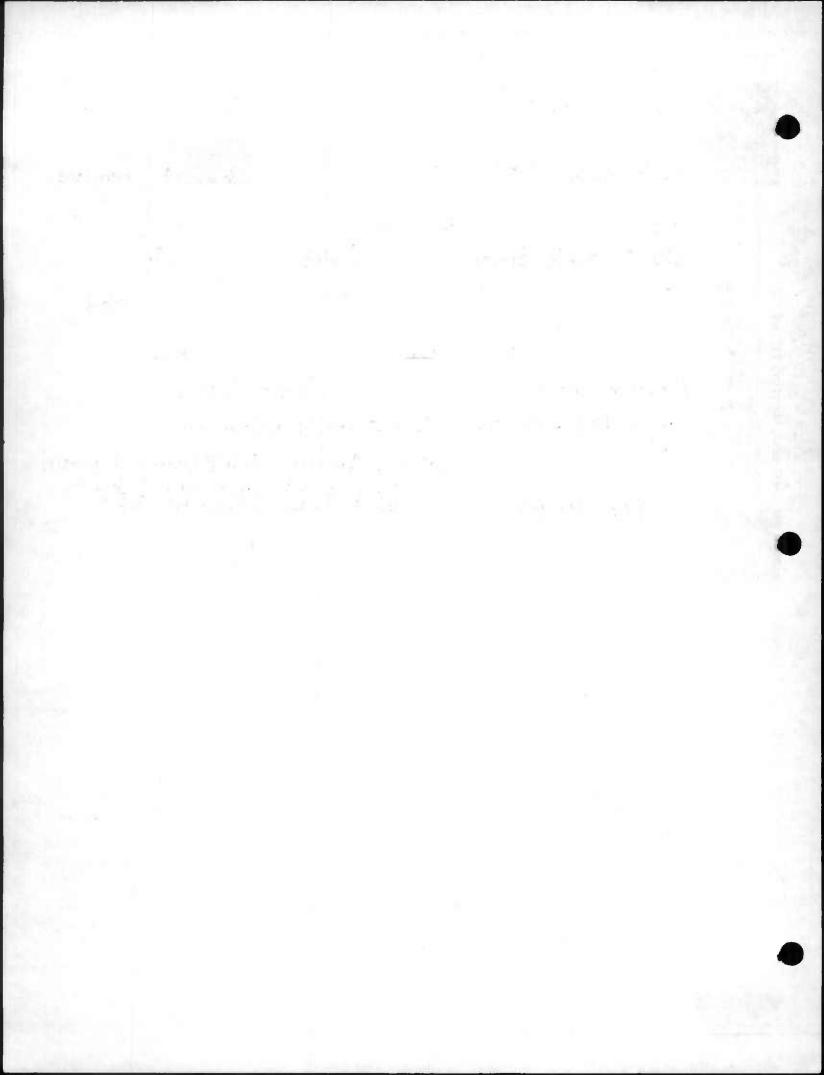
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State of Maryland / Department of Health and Mental Hygiene 2732

Amen	d: #16a Pe	er F	H Film G763 9-8-98RC Certificate of Death	Reg.		/ V los
	Physic	ian	1. Decedent's Name (First, Middle Last)	2. Date of Death	Day Yeer	3. Time of Deeth
	Physic /Medi		Marion Reid	SEPTEM DE	R 3, 1998	23/pm
	Exami	ner	4a. Fecility Name (If not institution, give street end number) Mercy Medical Center Bultimore	· ·	4c. County of Death	
	Funeral	7	5. Social Sacurity Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Undar 24 Hrs.	8. Dafa of Birth (Month, Day, Ye	9. Birthr	place (Stete or Foreign
	Director		212-52-5628 10 M 210 F 49 Yrs. Months Deys Hours Min.	6 26		yland
	hend we may		Usual Residence of Decedant 10a. State 10b. County 10c. City, Town or Location		1	10d. Inside City Limits
	Mary a-f sh	ctor	Md. Baltimore			15 res 2□No
0	with the Marylen a or 28a-f show	Dire	10e. Street end Number 10f. Zip Code	10g.	Citizen of What Cour	ntry?
3	deeth with the Marylend ims 23a or 28a-f show I. must be notified at	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Dacadent of Hispanic Origin? (Sp.	posify Voc or No.	14. Race - Amaric	oon Indian
. \ 0	urs efter deeth v al', or items 23s	Fun	Armed Forcas? If Yes, specify Cuben, Mexican, Puanto	Rican, etc.)	Bleck, White,	
A 1	72 hours ef	d by	3 ☐ Wildowed 4 ☐ Divorced If Yes, Give Yaar or Datas:		Specify: 15[ick
4 1	filed within 72 hours efter Hygiene. ther than "natural", or ite	Completed	15. Decedent's Education (Give kind of work done during most of work life. DO NOT use retired)	king 16b	. Kind of Business/In	dustry
8, 50	filed with Hygiene. Ither than	mo	Elementary/Secondary (0-12) College (1-4or 5+) UNK.	W	2K-	
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	0 2 2 0	5	HICKCORE RELO 19a. Informent's Name (Helationship (Type, Print) 19b. Mailing Address (Street end Number or Ru.	JUGOR-		Code
O/	12 mg		Harold Able · Brother 1616 Lating St. Bol	Lanza 14	iy 07 70WII, 01616, 24	Codey
Rallimore	S To L		20e. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place)	Dete 200	Location - City or To	wn, State
, ii	permit. Pages Department of I Important: If ite any injury or of		4 Donation 5 Other (Specify) Voshe Cemetery	1-10-98 130	altimore, l'	laryland
a	permit. Departmined imports any inju		21. Signature of Funerel Service Licansee 22. Name end Address of Facility 23. Signature of Funerel Service Licansee	ineral Ho	me & Ser	vices
	_	Н	23e. Part1. I must be disease, or complications that caused the death. Do not enter the mode of dying, such as cardiad shock, or he in feilure. List only one cause on each line.	or respiratory arrest,	d. 2121	Approximete
	Physician		shock, or ream feilure. List only one cause on each line.	0		Approximete Interval Between Onset and Deeth
	/Medical Examiner		Immediate Cause (Final disaasa or condition resulting In death) e.lloquirod temmune Deficiency	Synds	one i	enknoun
		Jer	Due to (or as e consequenca of):	0		
	Pula Line	Examiner	Sequentially list conditions, Due to (or es e consequence of):		1	
9	be exec		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events Due to (or es e consequence of): Due to (or as a consequence of):			
68760	ificate be executed g physicien (nd es the burial-transit	edicai	that initieted events rasulting in death) Lest Due to (or as a consequanca of):			
Box		an/M	d			
0	es that the death cert igned by the ettendin be deteched for use	Physician/N	Pert II. Other significant conditions contributing to death buf not resulting in the underlying cause given in Pert i.	23b. Did tobe	cco uae contribute t	o the cause of death?
0	that the	y Ph		1 Yes	2□ No 3□ Pro	bably 4 Uhknown
rds	v requires been sign should be	ed by		24a. Wes en e		ara autopsy findings
00	law request been 2 should	Completed		репоннес	CO	emplation of cause death?
<u>a</u>	The law cate hes			1 ☐ Yes		☐Yes 2☐No
Ž.	ysician: The is certificate director, peg	o Be	examiner /	th (Check only one)		
9	Attending Physician: The law requires that the death cer order After this certificate hes been signed by the ettendir by the funeral director, page 2 should be deteched for use	n: To	27. Manyer of Deeth 28e. Date of Injury 28b. Time of 28c. Injury et	28d. Describe how to	a 6 Other (Special Injury occurred	"HOSPICE"
i	eath. or: After the fune	catio	2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No			
Division of Vital Becords	or Att efter d Direct in by	Certification:	3 ☐ Sulcide 4 ☐ Homicide Sea. Placa of Injury - At home, farm, straet, factory, office building, etc. (Specify)	28f. Location (Stree City or Town, S	t end Number or Run tete)	Il Route Number,
	spital hours neral y filled	Sal	29a. Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete and plece,	end due to the ceus	e(s) and manner es s	iteted.
	To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Aedical	(Check only 2 LT Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occur end manner stated.	red et the time, date	and place, and dua to	o the cause(s)
	To Too	Σ	29b. Signature and fitle of certifier 29c. Licansa number 29c. Licansa number	294	Date signad (Month,	Dey, Year)
-	五		30 Name and address of person who completed cause of death (tem 23a) (Type Print) 7672 32	clair &	- JAMINER	11/18
			FORMANDO J. FERRO, MD Bulto	40 21	236	
	Sta		31. Dete filed (Month, Dey, Year) SEP 0 8 1998 32. Registrer's Signature S. Sparks			
	Registi	aı	JEL 0 0 1220			



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ROGERS Day **Physician** 14457trs ELIZABETH SEPTEMBER7, 1998 /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RANDAUSTOWN BALTIMORE NORTH WEST HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplaca (Stete or Foreign Country) 6. Sax **Funeral** 1 M 2 K F Days 64 Director 217-30-2996 MAryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours efter death with the Meryland Department of Heelth end Mentel Hygiane. Important: If Item 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumatic event, the Medical Exercise must be notified at once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. Baltimore Gwynn Oak 1 ☐ Yes 2 ☐ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7600 CLays Lane 21244 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ XNo If Yes, Give Year or Datas: 13. Was Dacedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Nevar Married 2 ☐ Married 1 Yes 2√No Specify: White p 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Coilege (1-4or 5+) Homemaker own home 11th 17. Father's Nama (First, Middle, Last) 18 Mother's Name (First Middle, Maiden Surneme) Earl Rogers Pauline Siedel 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Joseph E. Brader/ son 207 Bright Oaks Drive BelAir Maryland 21015 20a. Method of Disposition 20b. Placa of Disposition (Neme of cemetery, cremetory or other pleca) Date 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 □ Donation 5 □ Other (Specify) Metro Crematory Inc. 9/4/98 Baltimore Md. 22. Name and Address of Facility 21. Signature of Funeral Service Licanses Connelly Funeral Home of Essex 23a. Part1. Enter the disease, or commitcations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Finel disaase or condition resulting in death) ANOXIC ENCEPHALOPATHY /Medical **Examiner** Examine and I-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of): Physician/Medicai Due to (or as a consequance of): Division of Vital Records, P.O. Box Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Dld tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ACUTE MYOCARDIAL INFARCTION by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed complation of causa of death? hes 92 certificate ha 1 Yes 2 No 1 ☐ Yes 2 ☐No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Pinpatient 2 □ ER/Outpatient 3 □ DOA Certification: To this 28b. Time of 28d. Describe how Injury occurred 27. Menner of Deeth 28c. Injury at Work? After t 1 (ANetural 5 Pending 1 Yes 2 No investigation within 24 hours efter deeth To the Funeral Director: / completaly filled in by the 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide 1 Decrifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner es steted.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Cartifier edicai (Check only one) 29d. Data signed (Month, Dey, Year) 29c. License number 29b. Signatura and titla of cartifia D37333 wo SEPTEMBER 3, 1998

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

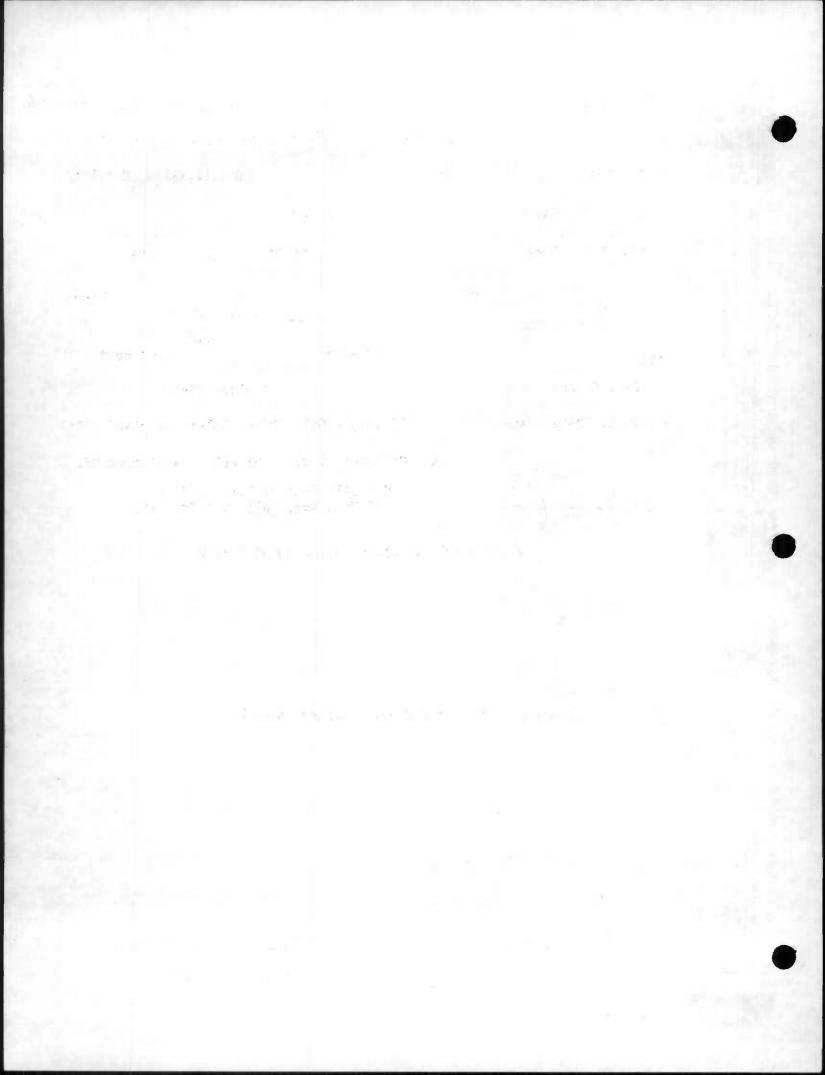
C. RAVI MD, NHC, BALTO, MD Z1133

parks

32. Registrar's Signature

RAVIMD, NAC

State



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Dey Year 2 50 Nancy Rowland - Grayson Lee 98 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth 4/6 MANSE BALTIMORE If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Dey, Yeer) NA If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplece (State or Foreign Country) 1□M 2₩ F Months Deys 173-34-3092 April 23,1944 Pennsylva NIA Usual Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Pres 2 □ No Maryland Baltimore 10e. Street end Number 10g. Citizen of What Country? 10f. Zip Code USA 476 MANSE 21201 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Rece - American Indian, Black, White, etc. 11. Meritel Stetus 1 Yes 2 10 If Yes, Give Yeer or Detes: 1 Never Married 2 Married 1 Yes 2 No Specify. Specify: White 3 Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) NUTSING Private Duty NUrse 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) DEAN Margaret Williams Paniel 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Carey T. GRAYSON, Jr. 20a. Method of Disposition MAUSE CT Baltimore MD 21201 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) Date 20c. Location - City or Town, Stete 1 ☐ Burlel 2 ☐ Cremetion 3 ☐ Removei from State Metro Saply,98 Baltimore 4 ☐ Donetion 5 ☐ Other (Specify) Crematory 22. Name end Address of Febility Ronald A. Grayson Funeral Service 21. Signature of Funeral Service Licensee 8312 Liberty Rd. Ballmore MD 21244 Umala (23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete fntervel Between Onset end Deeth Preumonia Immediate Cause (Final diseese or condition resulting in death) week Due to (or es e consequence of): ung cancer years Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initieted events resulting In deeth) Lest Due to (or es e consequence of): Due to (or as e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the causa of death? 1 Ves 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24a. Wes en eutopsy 1□ Yes 2☑No 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Date of Injury (Month, Dey Year) 28c. Injury at Work? 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Sulcide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 T Homicide

P.O. Box 68760 Division of Vital Records, or Attending Physician: after death. 24 hours a Funeral C Hospital

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after nant of Health and Martel Hygiene.
ant: if item 27 is marked other than "natural; or the mry or other traumatte event, the Madical Extransing my or other traumatte event, the Madical Extransing.

permit. Page Depertment of Important: If any Injury or page.

Physician

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page 2

funeral director,

certificate

After this

Examiner

Physician/Medical

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Completed

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Certification: To

Medical

29e. Certifier

(Check only one)

29b. Signeture end title of certifier

altimore, Maryland 21215-0020

Directo

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Completed

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the Merylend

To the Hosp within 24 ho To the Fune complately fi

Registrar

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) L. Austra Doyle, M.D.

mo

29d. Date signed (Month, Dey, Year) 3 & ptember

Baltimore, MD 21201

22 S. Greene St., Caucer Ctr., Green boum

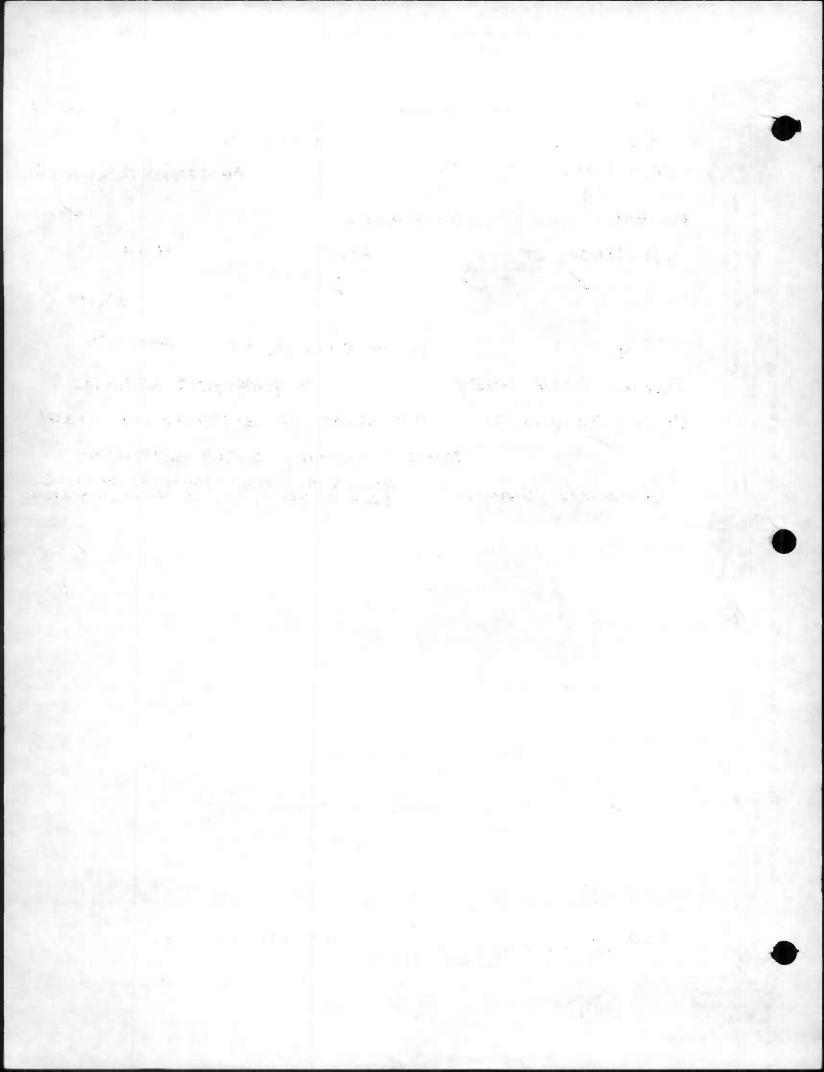
12 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date end plece, end due to the cause(s) end menner stated.

29c. License number

23809

31. Date filed (Month, Day, Year) SEP 0 8 1998 32. Redistrer's Signeture Separ



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death SEPTEMBER 3, 1998 **Physician** ROBINSON ELLA VIRGINIA 6:25 PM /Medical 4a Fscility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Towson Baltimore If Under 1 Year If Linder 24 Hrs 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) 9. Birthplaca (Stata or Foreign **Funeral** Days Months Hours 1 M 2 XF 218-07-8458 85 **Director** 11/16/12 MARYLAND Usual Rasidence of Decedant the Maryland 10e. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show avant, the Medical Examiner must be notified at 1 Yas 2 No Director BALTIMORE PARKVILLE 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? with 1 23a or death Funeral 7710 MIDDLESEX PLACE USA 12. Was Decedent Ever in U,S. Armed Forcas? Reme 11. Maritai Status Was Decedant of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, Black, Whita, atc. filed within 72 hours after 1 Nevar Married 2 Married 1 Yes 2 No If Yas, Give Year or Dates: Baltimore, Maryland 21215-0020 natural, or 1 Yes 2 No Specify: à Specify: 3 ₩ Widowed 4 Divorced WHITE Completed 16a. Decedant's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Hygiene. Elementary/Secondary (0-12) Collega (1-4or 5+) 11th GRADE SEAMTRESS GARMENT permit. Peges 1 end 2 should be file Depertment of Health end Mental Hy Important: if Item 27 Is marked other any Injury or other traumatic avant pace. 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middla, Maiden Surnama) 86 2 PATRICK O'NEILL UNAVAILABLE MARGARET 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) ROBERT ROBINSON SON 1224 WALKER AVENUE BALTIMORE, MD 21239 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1X Buriai 2 ☐ Cramation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Othar (Specify) GARDENS OF FAITH CEM. 9/8/98 PARVILLE, MD 21. Signature of Funeral Septi JOHNSON FUENRAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 PROF. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, which, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** CEREBRO VASCULAR THROMBOSIS 2 DAYS /Medical Immediata Cause (Final diseasa or condition rasulting in deeth) Examiner Due to (or es a consequence of) Examiner attending physician and for use as the burial ransit Sequentially list conditions, if sny, laading to immediata causa. Entar Underlying Causa (Disaase or injury that initiated evants rasulting in death) Last Due to (or as a consequence of): P.O. Box 68760, that the death certificate Physician/Medical Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 1 Yss 2 No 3 Probably 4 Unknown **ANEMIA** signed b Records, P The lew requires 24b. Wara autopsy findings available prior fo complation of cause of death? 24a. Wes an autopsy performed? Completed GASTROINTESTINAL BLEEDING page 2 has 2 XNo 1 Tas X No certificate Division of Vital Hospital or Attanding Physician: 25. Was case referred to medical axaminar?
1 ☐ Yas 2 ZNo Be 26. Placa of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residenca 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Panding s after des. al Director: Aft 1 ☐ Yas 2 ☐ No invastigation 2 Accident 6 ☐ Could not be detarmined 3 Suicida 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida To the Hospital or within 24 hours after To the Funeral Dir completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. edical 29a. Certifier (Check only one)

31. Dete filed (Month, Day, Year) 0 8 1998

BEATTRIZ P.

29b. Signatura and fitla of certifier

32. Registrar's Signature

30. Nama and address of person wife completed causa of death (Item 23a) (Type, Print)
BEATTRIZ P. DIZON, M.D., 7620 YORK ROAD TOWSON,

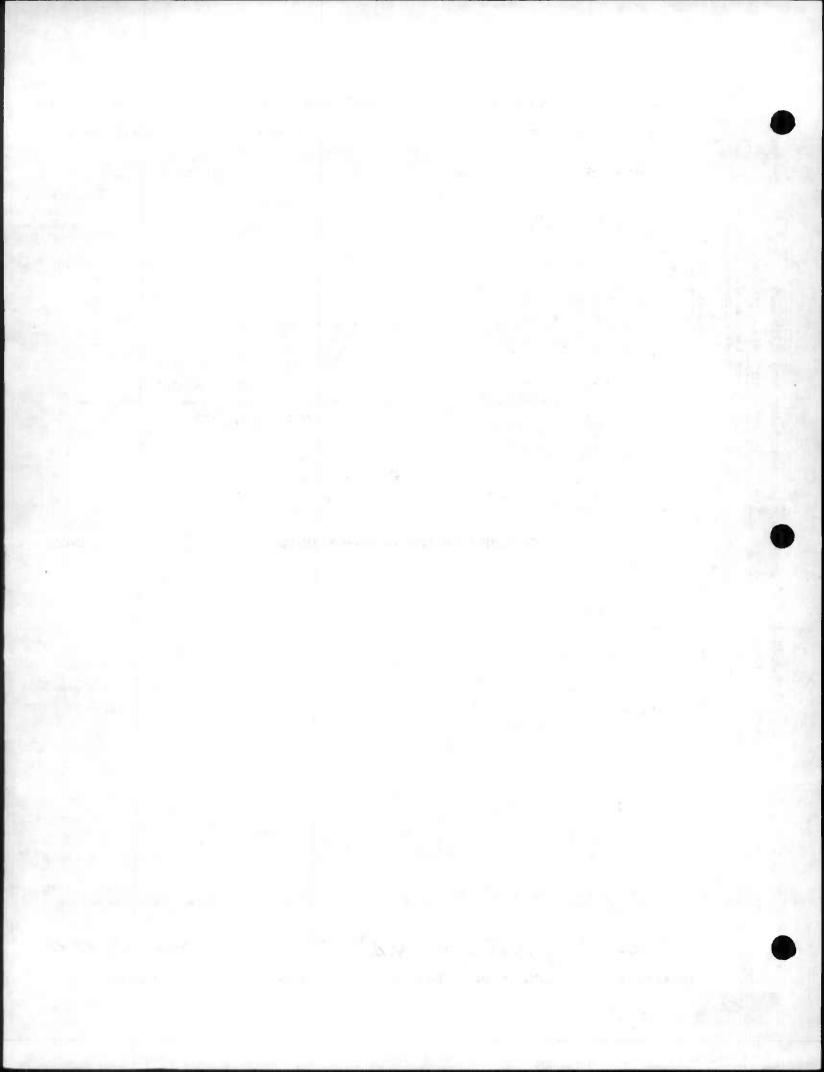
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29c. Licansa number

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29d. Data signad (Month, Day, Year)

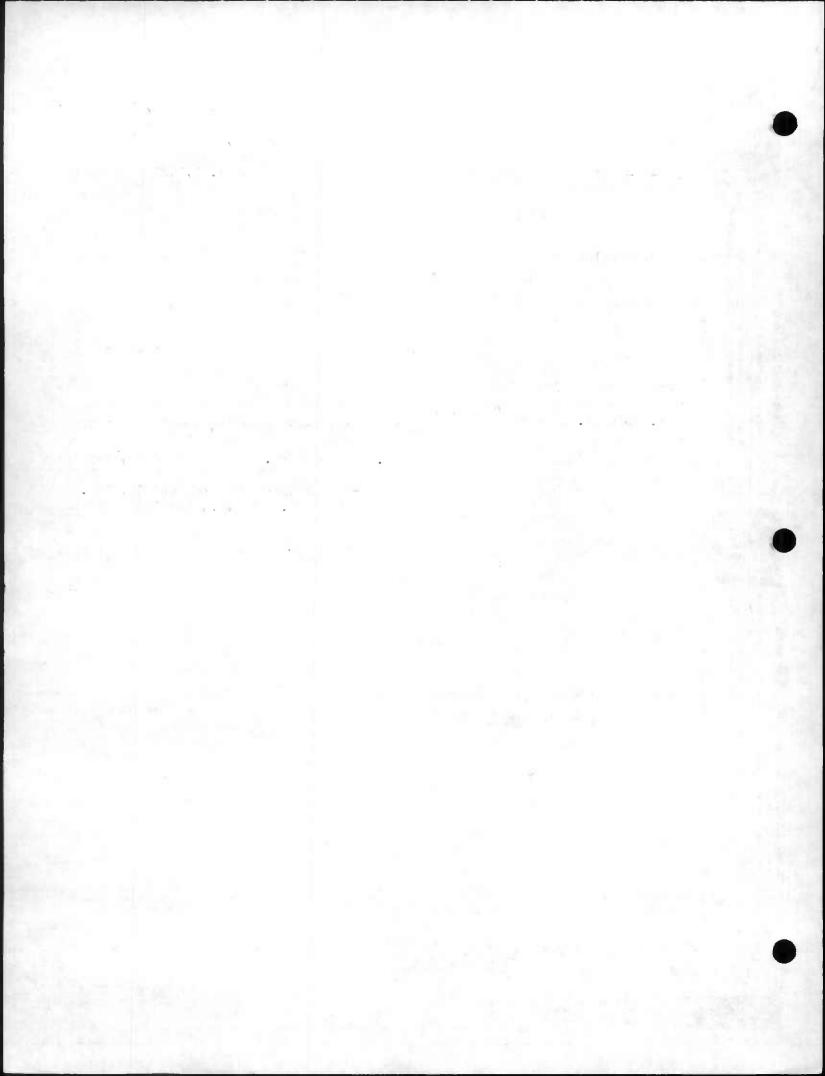
MARYLAND 21204



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

				Certificate	of L	eath		Re	g. No.	2	1325
Physician	Decedent's Nama (First, Middle, Li		ouise Sp	pence				2. Data of Death Month Septemb	Day	Year 1000	3. Time of Death 10:30 AM
/Medical Examiner	4a Facility Name (If not institution, gi	ve street and number)			48	o. City, Tox	wn, or Loc	cation of Death	4c. County		10:30 AP.
Examiner	2201 Searles Ro					D	unda	lk.		altimo	ore
Funeral Director	Social Security Number 6.		ge (In yrs. last birt	hday) If Under 1 Months I	Year Deys	ff Under 2 Hours		8. Dete of Birth (Month, Day, Dec. 1		9. Birthpl Count	leca (Stete or Foreign try) y land
	Usuat Residence of Decedent		04					Dec. 1	,1555	Tial	, Idila
death with the Maryland ma 23a or 28a-f show creat be notified at neral Director	10a. State 10b. County Maryland	Baltimore	10c. City, Town	or Location		Dund	lalk			10	0d. Inside City Limits 1 ☐ Yes 2 💆 No
ith with the Ma 23a or 28a-fe unt be northler al Director	10e. Street and Number 2201 Searles Ro	ad		10f. Zip C	Code	2122	2	10	og. Citizen of V		
ozo ura efter aff, or fte menon by Fui	11. Marital Status 1 Never Married 3 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2X If Yes, Give Yeer or Dates:	4 - 4	13. Was Deceder If Yas, specify 1 Yes 25			gin? (Spe , Puerto F	cify Yes or No- Rican, atc.)		e - America ck, White, e	
15-002 n 72 hours "natural", noted by	15. Decedent's E	ducation	16a.	Decedent's Usual	Occupa	tion		1	6b. Kind of Bu	usiness/Ind	lustry
2121 I within fiene. The transfer	(Specify only highest gr Elementary/Secondary (0-12) 12 Years	College (1-4or		(Give kind of work tile. DO NOT use ecretary	retired)	unng most	OF WORKIN	19	Cler	cical	
ind 2 be filled tai Hygin d other event, it	17. Father's Name (First, Middle, Last	1)				18. Mothe	r's Nama	(First, Middle, M	laiden Suman	10)	
should be flied and Mental Hygi I marked other urratic event, I To Be Co.	John Staudenmai	er				Ev	a Ba	rnes			
Maryland d 2 should be file tith and Mental Hy 7 is marked othe traumatic event To Be C	19a, Informant's Neme/Relationship	(Type, Print) (H110	sband) 19b.	Mailing Address (Street a	nd Numbe	r or Aura	Route Number,	City or Town,	State, Zip	Code)
and 2 auth	Mr. Rufus L. Sp	ence		201 Searl	les :	Road	Dun	dalk, M	arvland	21:	222
Baltimore, Maryland 3 permit. Pages 1 and 2 should be filed Department of Health and Mental Hyp Important: if item 27 is marked other any injury or other traumatic event, page. To Be C	20a. Method of Disposition 1 Surial 2 Cremetion 3 C 4 Donation 5 Other (Speci		20b. Place of cemeter	Disposition (Name y, cremetory or other d Ht. of	e of er plece)		Deta 2	Oc. Location -	City or To	wn, State aryland
Balti permit. Departm importa any inju	21. Signature of Funeral Service Lice	nsee Like		22. Name end	Address	s of Facility	у	Home of	Dundal	lk, I	nc.
	23a. Part Fritter the disease, or conshock, or heart tailure. List only	nplications that caused one cause on each li	d the death. Do r	ot enter the mode	Vise of dying	Ave.	Du cardiac o	ndalk, I	Marylar st.	nd 2	1222 Approximate Interval Betwaan Onset end Death
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	. Cer	die	01	10	A				/	WWW.
2 # E		A	SC V	onsequence of):							year
760, to be executed yaidarrend to burlat-familia	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	c	Due to (or es a c	onsequence of):							
Med The	that initiated events resulting in death) Last	d	Due to (or as e c	onsequence of):							
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Physician Physics Phys	Part It. Other significant conditions	contributing to death b	out not resulting in	the underlying cau	ise give	n in Pert f.			bacco use co	1/	rthe cause of death? bably 4 Unknown
cords requires should be leted by		01-						24a. Wes ar		ava	ara eutopsy findings allable prior to mpletion of cause deeth?
The law								1∏ Ye	s 2 No		Yes 2 No
vital I sician: The cardificate lirector, pay	25. Was case referred to medicat					26 Place	of Deeth	(Check only one			, 100 203110
V alcient	examiner?	Hospital:	ent 2 ER/Ou	patient 3 DOA	Othe			ne 5 Aneside		er /Snecih	41
0 4 22 1	27. Manner of Death	28a. Dete of Inju		ima of 28d	c. Injury Work			8d. Describe ho			7
Attending Is a death. Petor: After by the fune	1 Pending 2 Accident investigation		y Year) Ir	njury M		? 'es 2 ☐ l	No				
T telle t	3 Suicide 6 Could not be determined	28a. Place of Inj	jury - At home, fer c. <i>(Specify)</i>	m, street, fectory, o	office		2	8f. Location (Str City or Town		er or Rura	l Route Number,
To the Hospital Within 24 hours a To the Funeral Completely flued		nysician: To the best miner: On the basis of and manner st	f examinetion end								
To the west of the transfer of	290. Signature and title of certifier	0,	. 1	29c. I	License	number	6,4	D 21	C)3	d (Month, i	Pay, Year)
6	30 Marine and address of person who	completed cause of d	leath (Item 23a) (Type, Print)	N	PT	, /	5	Bore	Me	22124
State	Date filed (Month, Day, Year)	32. Registr	er's Signature	1					, ,,,,,,		/



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth SEPTEMBER 6, 1998 coation of Death 4c. County of Deeth 5:30 AM 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death MARYLAND GENERAL HOSPITAL BALTIMORE HUnder 24 Hrs. 8. Date of Birth Mours Min. Month, Dey, Years June 2, 49 7. Age (In yrs. lest birthday) If Under 1 Year Months Deys 5. Sociel Security Number 6. Sex Binhplece (State or Foreign ACountry) 216-32-1021 Usuel Residence of Decedent 10 M 20 F Yrs. land 10e. Stete 10b. County 10d. Inside City Limits 1 No 2 No laryland 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? Heights 14. Race - American Indien, Bleck, White, etc. 11. Maritel Stetus Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) I ☐ Yes 223 If Yes, Give Yeer or Dates: 1 Never Married 2 ☐ Married 200 No 1 ☐ Yes 2 No Specify: Specify: Negro 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working iife. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Worker rivate 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 19a. Informent's Neme/Relationship (Type, Print) (SISTER) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Ada 4120 Mo Fairtax 20b. Placa of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burlel 2 □ Cremetion 3 □ Removel from State LIDN 4 ☐ Donetion 5 ☐ Other (Specify) of Funerel Service Licenses 22. Name end Address of Fecility Joseph W. North Ave. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, or heart to the mode of dying, such as cardiec or respiratory errest, or heart to the mode of dying, such as cardiec or respiratory errest, or heart to the mode of dying, such as cardiec or respiratory errest, or heart to the mode of dying, such as cardiec or respiratory errest, or heart to the mode of dying, such as cardiec or respiratory errest, or heart to the mode of dying, such as cardiec or respiratory errest, or heart to the mode of dying, such as cardiec or respiratory errest, or heart to the mode of dying, such as cardiec or respiratory errest, or heart to the mode of dying, such as cardiec or respiratory errest, or heart to the mode of dying, such as cardiec or respiratory errest, or heart to the mode of dying, such as cardiec or respiratory errest, or heart to the mode of dying and the death. Immediate Cause (Final disease or condition resulting in deeth) UROSEPSIS Due to (or es e consequence of): OBSTRUCTION Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in deeth) Lest DIABETES MELLITUS Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Pronknown 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24a. Was an autopsy periormed? 1 Yes 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? 1 ☐ Yes 2 ☐ No 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Deeth 1 Neturel 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred

Physician /Medical **Examiner** Pull

Physician

/Medical

Examiner

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7 is marked other than "naturel", or frems 23e or 28a-f show treumetic event, the Medical Examiner must be notified at

other

any injury or

pernit. Pages 1 and 2 should be filed within 72 hours effer deeth Department of Health and Mental Hygiene. Important: If Item 27 ie marked other than "naturel", or Items 23.

Maryland 21215-0020

Baltimore,

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Examiner

certificate hes To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this certifica

Physiclan/Medical Division of Vital Records, P.O. by Completed Certification: To

completely

Registrar

Medical

6 Could not be determined 3 Suicide 4 Homicide

5 Pending investigation

2 Accident

(Check only one)

29b. Signature end title of certific

29a. Certifier

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury et Work? 1 Yes 2 No

MD

1 Certifying Phyelcian: To the best of my knowledge, death occurred et the time, dete end place, end due to the cause(s) end menner es steted. 2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner stated.

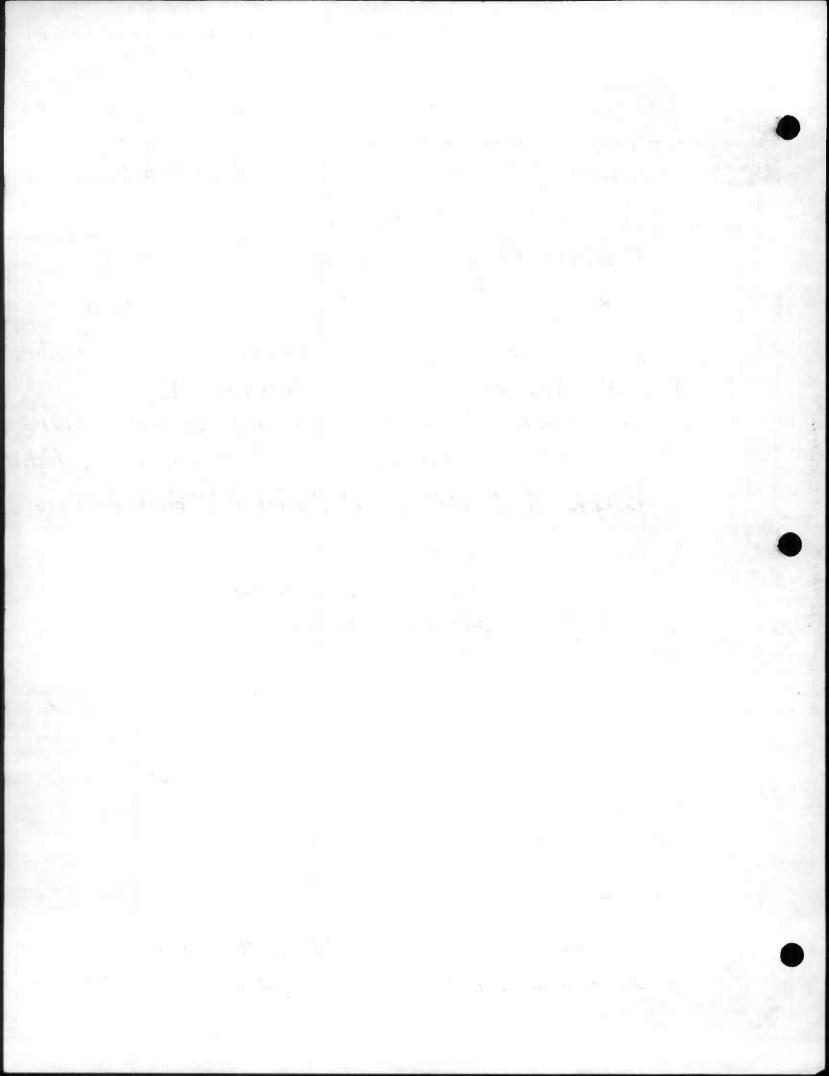
GENERAL

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

HOSPITAL

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

DANUSHKODI 31. Dete filed (Month, Day, Year) SEP 0 8 32. Registrar's Signature 8



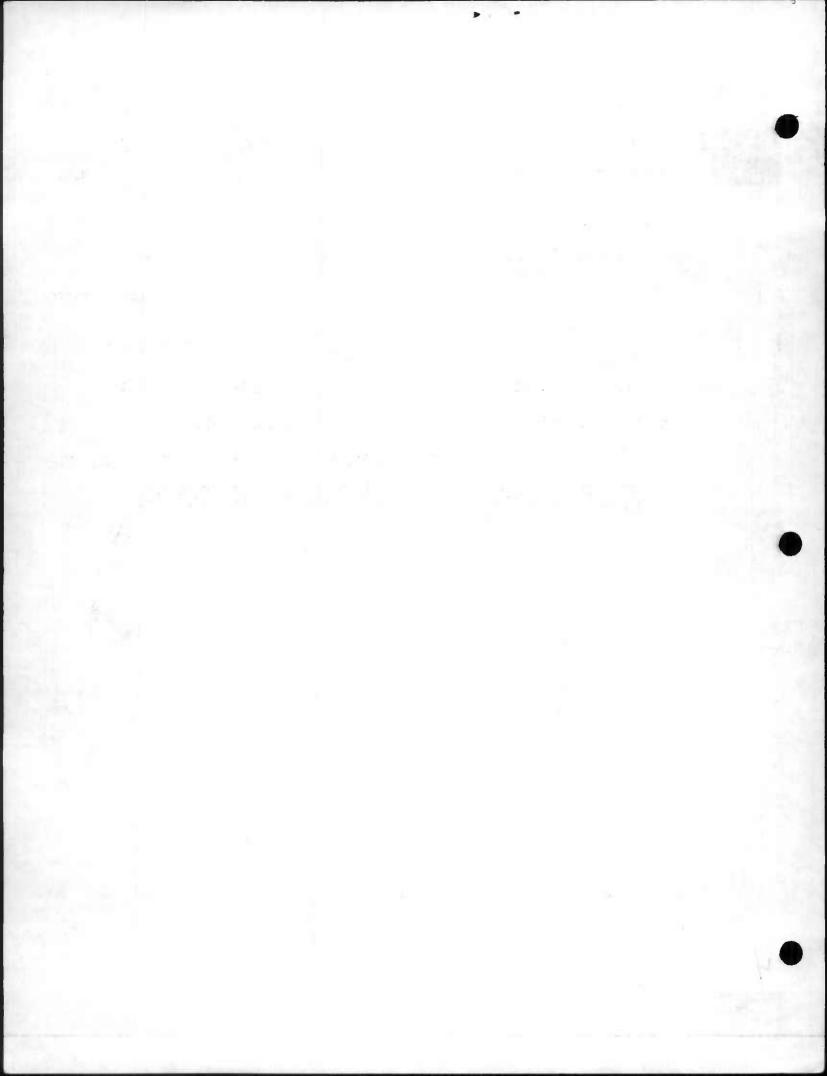
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middla, Last)_ 2. Data of Death SEEBERRY **Physician** MATTIE September Day 3.20 PH ,51 /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Daath 4c. County of Death **Examiner** GOOD SAMARITAN BALTIMORE N/A If Undar 1 Yaar If Undar 24 Hrs. Hours Min. 5. Social Sacurity Number Dete of Birth (Month, Day, Year) 12/20/01 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** 1□ M 2∰ F Days 96 Yrs. Director 216 03 0522 N.C. Usual Rasidanca of Dacedan the Marylend 10a Stata 10b County 10c. City. Town or Location 10d. Insida City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Yas 2□No Director BALTIMORE MD. N/A 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 2637 GARRETT AVF. 21218 USA Funeral 12. Was Dacadant Evar In U,S. Armed Forcas? 1 ☐ Yas 2#☐ No If Yas, Giva'' Yaar or Datas: 11. Marital Status Was Dacedant of Hispanic Orlgin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 72 hours after 1 ☐ Navar Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yas 2#□ No Spacity: Specify: AFRO AMERICAN by 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry should be filled within 7. and Mantal Hygiene. s markad other than "na Elemantary/Secondary (0-12) Collaga (1-4or 5+) ENOCK PRATT 12 0 CUSTODIAN permit. Pages 1 and 2 should be file Depertment of Health end Mantal Hy Important: If Itam 27 is marked otha any Injury or othar traumatic events 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) **JAMES** HICKS LIZA HICKS 19a. Informant's Name/Reletionship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Routa Numbar, City or Town, Stata, Zip Coda) BESSIE M. McGOWAN 2637 GARRETT AVE. BALTO. MD. 21218 20b. Place of Disposition (Nema of cematary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burlal 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY 9/8/98 CATONSVILLE, MD. 21. Signatura of Funeral Service Licensee 22. Nama and Addrass of Facility
ESTEP BROTHERS F
1300 EUTAW PL. FUNERAL HOME BALTO. MD. 23a. Part1. Enter the disaasa, or complications that causad the death. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batw Onsat and Death **Physician** /Medical Immediata Cause (Final disaasa or condition resulting in daath) Examiner Due to (or as a consequence of): Examiner arrythmia burial-transit Sequantially list conditions, if eny, laading to immadiata causa. Entar Underlying Couse (Disaasa or Injury that initioted events rasulting in daath) Last Dua to (or as a consaquance of) pue Physician/Medical Dua to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Vunknown þ 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed certificate 1 Yas 2 No 1 Yas 2 No To the Hospital or Attanding Physician: within 24 hours aftar death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I 25. Was casa rafarred to medical Be 26. Placa of Daath (Check only one) Othar: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatiant 3 ☐ DOA artar death.

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2 Medicat Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. Licansa numbar 6 6 1 29d. Data signed (Month, Day, Yaar) 29b. Signature and titla of certifiar pleacen plember 30. Nama and addrass of parson who completed causa of death (Item 23a) (Type, Print) TRIPURANENT 13 W. RINGFACTORY PD, BREAIR, MD. 21014 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State SEP 0 8 1998 Registrar



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Registrar

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Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Dorothy Trust September 6 1998 8:30pm 4b. City, Town, or Location of Daath 4a Facility Name (If not institution, give street and number) 4c. County of Death 142 Arundel Beach Rd. Severna Park Anne Arundel If Under 24 Hrs. 8. Date of Birth (Month, Day,) 3/6/1910 If Undar 1 Year 5. Social Security Number Birthplace (State or Foraign Country) 7. Age (In vrs. last birthday) 6 Sax 1 M 2 XF Months Days Yrs. 88 Maryland 215-18-6531 Usual Residence of Decedan 10a Stata 10b County 10c. City. Town or Location 10d. Insida Clty Limits 1 Yas 2 No Anne Arundel Severna Park 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 142 Arundel Beach Rd. 21146 USA 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 [XNo If Yes, Give Yaar or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, atc.) 14 Race - American Indian. Black, White, etc. 1 Never Married 2 Married Specify: White 1 Yes 2 No Specify: 3 X Widowad 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grada completed) Elementery/Secondary (0-12) College (1-4or 5+) 8 Homemaker Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Daniel Fenning Clara Thomas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) 142 Arundel Beach Rd. Severna Park, MD 21146 Robert W. Trust, Sr. son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 M Cramation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 9/10 Catonsville, MD 22. Name and Address of Facility Barranco & Sons PA Severna Park Funeral Home 23a. P. 11. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Ap. 23a. P. 11. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Ap. 25a. P. 11. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Ap. 25a. P. 11. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Ap. 25a. P. 11. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate Interval Between Onsat and Death Immediate Cause (Final · CANDIAL 1+0 disease or condition resulting in death) CAMPIONASEULAN 773noscullyone Sequentially list conditions, if any, laading to immadiate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Dua to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yss 2 No 24b. Were autopsy findings aveilable prior to complation of cause of death? 24a. Was an autopsy 1 Yes 1 TYes 2 No 25. Was cese referred to medical examiner?

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

Funeral

Director

7 is marked other than "natural", or frams 23a or 28a-f show traumstic event, the Magneta Examenar must be notified at

pernit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mantel Hygiene. Important: If item 27 is marked other than "natural", or the sny Injury or other traumatic event, I'm Manies Insurant

with the Maryland

death

Maryland 21215-0020

altimore,

Physician/Medical Examiner SS þ

Completed

Be

10

Certification:

edical

signed by to bean hes page 2 cartificate funaral director, this Aftar

Box 68760 Division of Vital Records, P.O. Attending after death. ò Hospital 24 hours

To the I within 2. To the F

SHAL State Registrar

1 Yes 2 No

5 Pending investigation

6 Could not be determined

27. Manner of Death

1 Natural 2 Accident

3 Sulcide

29a. Certifier

4 T Homicide

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (item 23e) (Type, Print) 1.0

28a. Date of Injury (Month, Day Year)

32. Bégistrar's Signature Maria

1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

28e. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify)

28b. Time of

Injury

518CAMP MBADINAD. LINITACUA.

28c. Injury at Work?

Cartifying Phyalcian: To the best of my knowledge, death occurred at tha time, data and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 ☐ Yes 2 ☐ No

26. Piace of Death (Check only post)

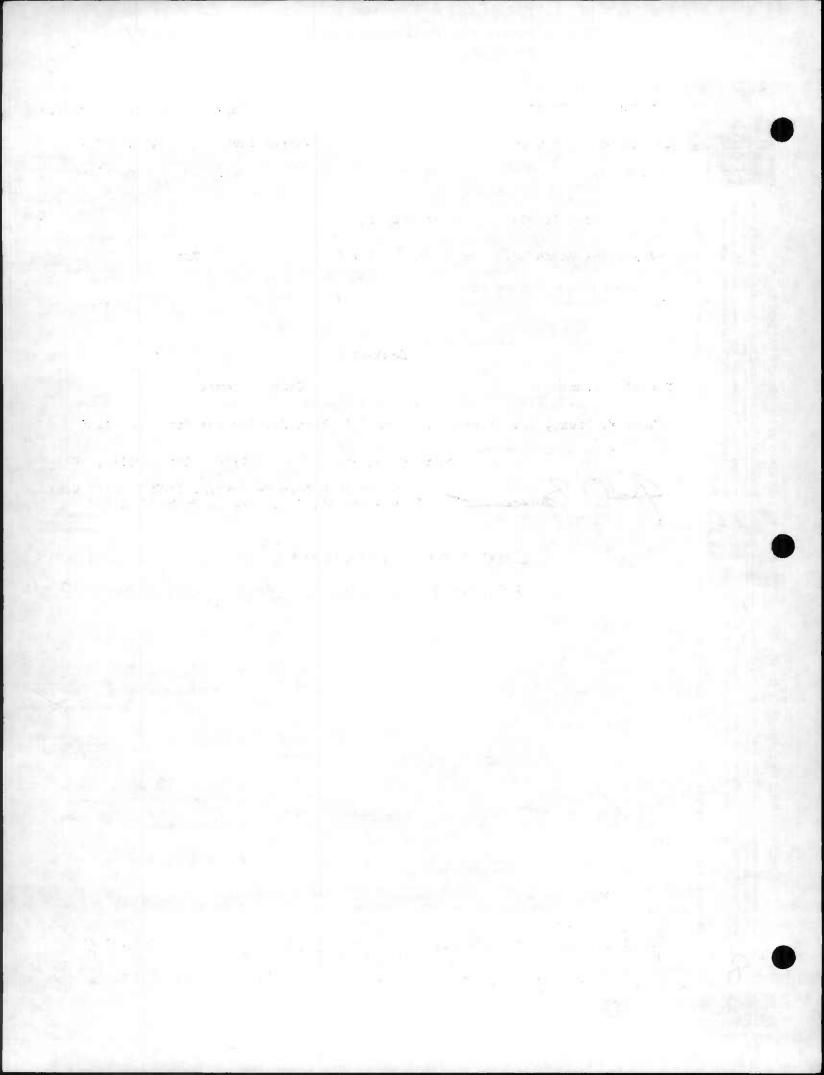
Other: 4 Nursing Home Residence 8 Other (Specify)

28d. Describe how injury occurred

281. Location (Street and Number or Rural Routa Number, City or Town, State)

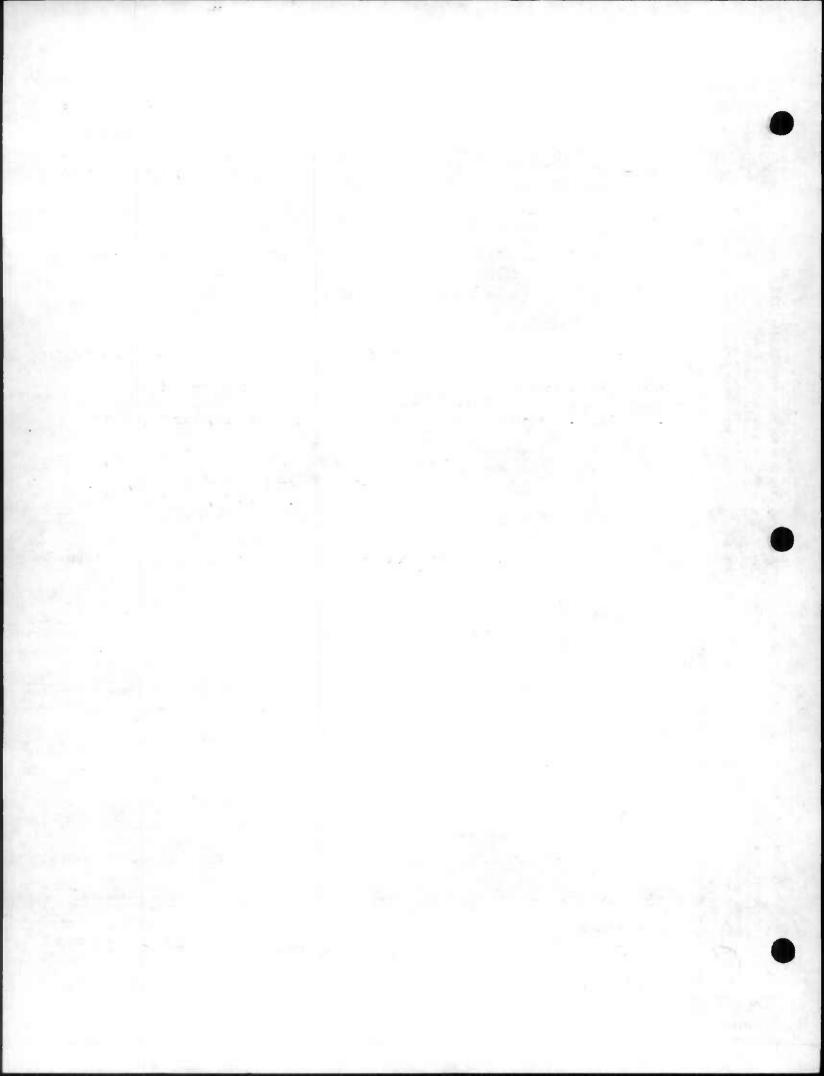
29d. Date signed (Month, Day, Year)

21090



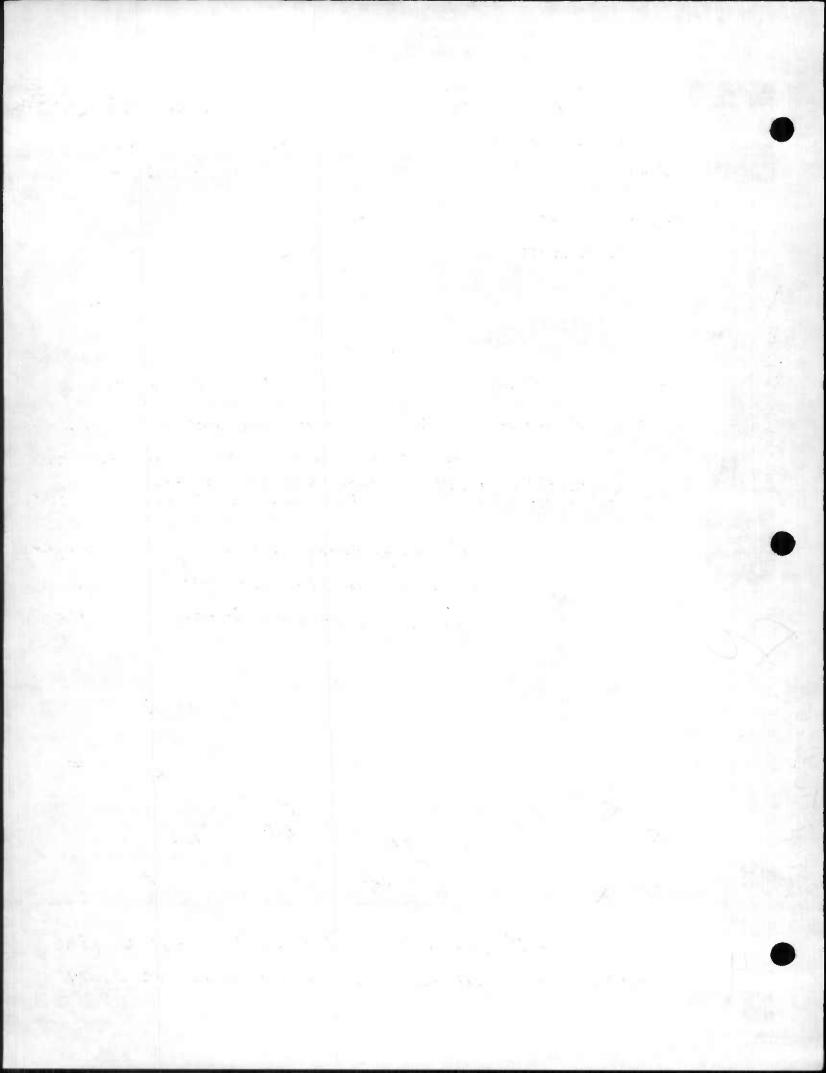
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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ш	Physician	Decedent's Neme (First, M.	iddia, Last)		T. J		Thomas			2. Data of De Month	Dev	Year	3. Time of	
	/Medical	4a Facility Nama (II not instit	tion aive a	Frank		na	Thomps	-	lb. City, Town, or L	_		1998	5:30	MA O
51	Examiner	300 Long Cov							Essex	00211017 01 0001	,	altim	ore	
	Funeral	5. Social Security Number	6. Sex		ga (In yrs. la	ast birthday	y) If Under		If Under 24 Hrs.	8. Data of Bir (Month, Da			lace (State or	Foreign
	Director	218-32-1431 Usual Rasidance of Decedan		M 2 F	75	Yrs.	Months	Days	Hours Min.	July	23,1923		yland	
	anylano ahow	10a. Steta 10b. Con Florida			10c. City	, Town or I		v.:				11	0d. Inside City	
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	with t			01			10f. Zip	Code	2.47.4		10g. Citizen of 1			
	fler deeth v	219 Westmore		2. Was Decedent	Evar in U.S	5. 13	. Was Deced	ent of H	3474	_	United	a Stat		
21215-0020	by by	3 ☐ Widowed 4 ☐ Divor	Married	Armed Forces 1 Yas 2 H If Yas, Giva Year or Detas:	?		If Yas, spec		ispanic Origin? (Sp an, Mexican, Puarto Specify:	Rican, atc.)	Specify Specify	ck, Whita,		
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	1 end 2: Health ar arm 27 is other trau	Mr. Douglas							lace Be				015	
ore,	of Hei	20a. Mathod of Disposition	- 0-		20b. Pl	ace of Disp	position (Name	na of ther plac	ne)	Data	20c. Location -	City or To	wn, Stata	
E	Pag net: H iny o	1 ☑ Burial 2 ☐ Cramati 4 ☐ Donation 5 ☐ Otha		amovel from Stata			n Cemet			998	Baltin	nore,	Maryla	and
Baltimore,	pemit. Pag Department Important: I any Injury o phos.	21. Signature of Funaral Serv	ice License	ess					ss of Facility Funeral I Ave. Du					
		23a. Part (Entar the disease shock, or heart failure.	, or complic	cations that cause	d tha daath							1 21.	222 Approximata Interval Betw	
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98	5 O 0	rasulting in death) Last		0	Due to the	es e conse	equenca of):							
Вох	let the death certing the attending etached for use a Physician/M		d.									1		
	5 e 7 -	Pert II. Other significant cond	litiona cont	ributing to death b	out not rasu	Iting in tha	underlying ca	ause giv	en in Pert I.	23b. Did	tobacco uae co	ntribute to	the cause o	f death?
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	tal or Attanding Presented at Director: After led in by the funeraction:	4 Homicida det	benimed	28a. Place of In building, at	c. (Specify)	ne, tam, s	treet, factory,	, office		City or To	Street and Numb wn, State)	oer or Hura	I Houta Numb)0r,
	to the hospital or Attanding within 24 hours after death of the Funeral Director: After complately filled in by the fune Medical Certification	29a. Certifier 1 Certifier (Check only one)	lying Physi al Examin	clan: To the best er: On the besis o and manner st	f axaminati	rledge, dea on and/or li	ith occurred envestigation,	ot tha tim	na, data and place, pinion, deeth occur	and dua to tha red at the time,	cause(s) and mo data end place,	annar as st end due to	ated. the cause(s)	
	Me Me	29b. Signetura end little of part	ifier	10			29c.	Licans	e number		29d. Data signe	d (Month,	Day, Year)	
		1 SHOW	Elih	Lolo	- La	M	2	Do	2191		Sept	4,	1998	
40	23	30. Nama and address of pers	on who cor	npleted causa of o	leath (Item	23a) (Type	Deint)		ek ave.	Baltin	100 M	D 21	022	
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State of Maryland / Department of Health and Mental Hygiene

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miner	4e Facility Neme (If not institution, giv					4b. City, Town, or	Location of Death	4c. County	of Death	
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erai .	5. Sociel Security Number 6. S	ax 7. A		aut Dirtinday/	Under 1 Year	If Undar 24 Hrs Hours Min.		, Year)	9. Birthplace (Stete or Foreign
	413-01-3932	UM ZUF		86 Yrs.			JAN. 5	, 1912	Pennsy]	vania
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			Too. Ony	, TOWN OF LOCAL						Yes 2 No
55	Maryland Har:	ford			Bel.	Air				7100 577110
Director	10e. Street and Number				10f. Zip Code			log. Citizen of V		
Funeral	410 E. MacPha	ail Road				21014			SA	
I G	11. Maritel Status	12. Was Decedent Armed Forces		S. 13. Wa	s Decedent of as, specify Cu	Hispanic Origin? (S ban, Mexican, Puer	Spacity Yes or No- to Rican, etc.)	14. Rac Bled	ce - Americen Inc ck. White, etc.	lian,
	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 📉			Yes 2X No			Specify		
5	3 X Widowed 4 □ Divorced	Year or Dates:						Specify	Whit	e
e e	15. Decedent's Ed (Specify only highest gra	lucation da completed)		16e. Deceden	t's Usual Occu	pation during most of wo	rking	16b. Kind of Bu	usiness/Industry	
Be Completed	Elementary/Secondary (0-12)	College (1-4or	5+)			during most of wo				
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	17. Father's Nama (First, Middla, Last,						me (First, Middle,			
	Willard B. Ha	artman				Lilli	lan Pear	rl Mey	ers	
	19a. Informant's Name/Relationship (Type, Print)		19b. Mailing	Address (Stree	et end Number or R	ural Route Numbe	r, City or Town,	Stete, Zip Coda)
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	20a. Method of Disposition		20b. P	lace of Dispositi	on (Name of	treet Up	Date	20c. Location -	City of Town, S	tate
	1 ☐ Buriat 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif					nc.	0/9/09	D = 1 +	·	MD
-	21. Signatura of Juneral Service Licer		I'LE C.	22 V	lame and Add	ress of Facility	9/0/90	Dalt	imore,	MD
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	resulting in death)		Due to (o	r as a conseque	nce of):	,				
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	Sequantially list conditions,	0.	Due to (or	as e conseque	nce of):		2			
1	Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events		Per	· Men	AL UX	y Dike	puses	n	17	ERS
CB	that initiated events resulting in death) Last	C		as a conseque						
Med	rosuling in death) Last									
Physician/N		d								
200	Pert II. Other significent conditions of	ontributing to death I	out not resu	ilting In the unde	erfying ceuse r	iven in Part I.	23b. Did t	obacco use co	entributa to the	cause of death?
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							24a. Wes	an autopsy	24b. Were au	topsy findings
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Completed							101	es No	1 LTYes	2□ No
0	25. Wes case referred to medicet examiner?	Hospital:				26. Place of De	eth (Check only o	ne)		
Be	1 Tyes 25 No	Hospital: 1 ☐ Inpat			3LI DOA	410 Nursing I	Homa 5 Resid			
2		28a. Date of Inj	y Year)	28b. Time of Injury		ork?	28d. Describe	iow injury occur	1180	
2	27. Menner of Deeth 1 2Natural 5 ☐ Pending		4	M	M 1[☐ Yes 2☐ No	^			
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2	27. Menner of Deeth 1 Natural 5 ☐ Pending	28e. Place of In	jury - At ho	me, ferm, stree		9	City or Tox	m, Stata)		
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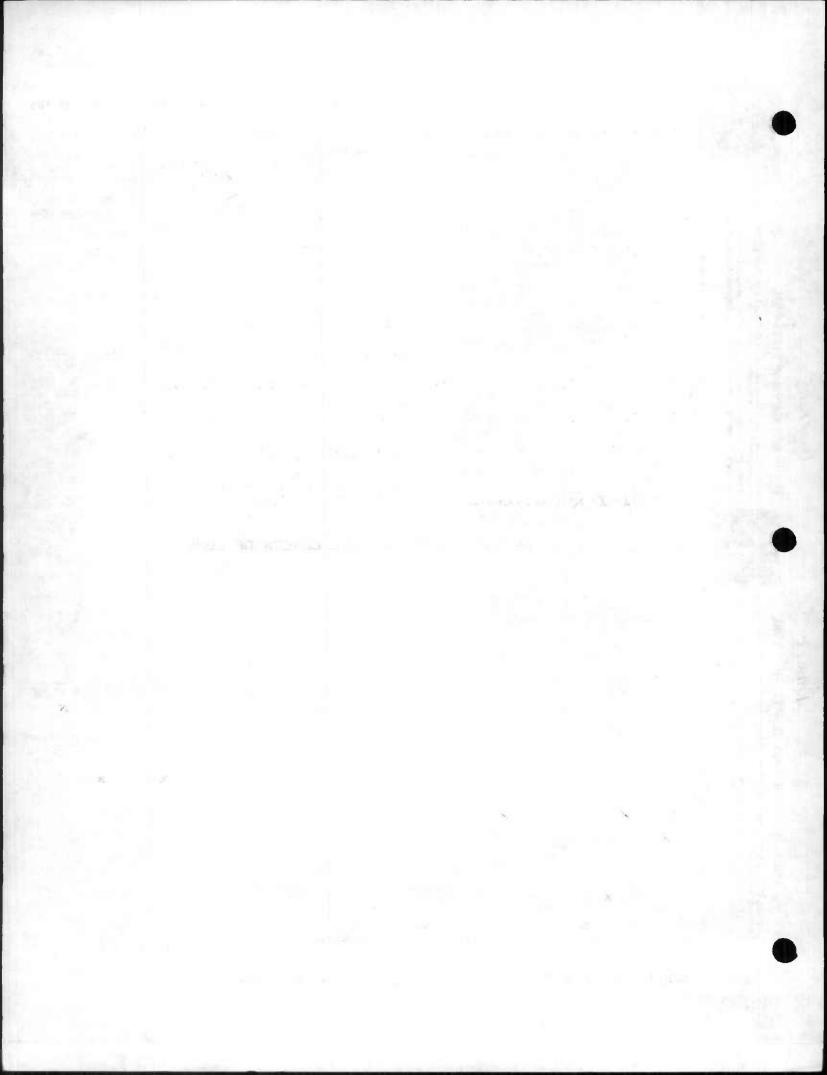


		State of	Marylano	-	artment of F tificate of			Reg. No. 9	27	1332	
Physician /Medical	Decedent's Name (First, Mide ROBERT	die, Last) CHARL	ES		TOMPK	INS	2. Data of De Month S 6	Dev	Year 998	3. Time of Dec	
Examiner	4a Facility Neme (If not institution Saint Josep			er		4b. City, Town, or TOWS			of Death	more	
Funeral Director	5. Social Security Number 216 44 9527	6. Sex 102 M 2□ F	7. Age (In yrs. la 74	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	8. Date of Bir (Month, Da Aug. 2	th ly, Year) 23,1924	9. Birthple Countr Oh:	ece (Stete or Fo	oreigi
pue *	Usual Residence of Decedent 10a. Stata 10b. Count	v	10c. City.	Town or Lo	cation				100	d. Inside City L	imits
Maryl Hahe Hed	Maryland Ba	ltimore			Т	owson				1 ☐ Yes 2X	
3a or 28a-f a st be notified i Director	10e. Street and Number 541 Valley Vie	w Rd.		1	10f. Zip Code	21286		10g. Citizen of V United		•	
172 hours after death with the Maryland "neturel", or flame 23a or 28a-f ahow after Exercises must be notified at leted by Funeral Director	11. Merital Status 1 Never Married 2 Ma 3 Widowed 4 Divorce	Armed For	8		Vas Decedent of H f Yes, specify Cuba I ☐ Yes 2 No		Specify Yes or No to Rican, etc.)	Blee	ce - America ck, White, et y: Whi	tc.	
od within 72 horygiane. or than "nature it, fre treated Completed	15. Decede (Specify only high	nt's Education est grada completed)		16a. Deced	lent's Usual Occup kind of work done DO NOT use retire	pation during most of wo	rking	16b. Kind of B	usiness/Indu	istry	
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Tother Hygin	17. Father's Neme (First, Middle			Nes	earch ch		me (First, Middle				
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2 4 4 4	19a. Informent's Neme/Relation Joan E. Tompk			541 V	ag Address (Street alley Vi					2ode)	
Pages int: If its ary or o	20a. Method of Disposition 1 Burial 2 remetion 4 Donation 5 Other (Cer	netery, cren	sition (Name of netory or other plan nt Crema	tory 9/	Date 10/98	20c. Location - Balti	City or Tow MOTE,		
pemit. Pag Department Important: I any injury o	21. Signature of Funeral Service	Licensee		22 C	Name and Address AFA Step 717 Gree	hen D. L	ohrmann	P.A.	ro M	D 2128	26
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odical Cert	29a. Certifier 1 □ Certifyl (Check only 2 ■ Medica	ng Physician: To the la	best of my knowl	edge, deeth	occurred et the tir	me, date and plac	e, end due to the	cause(s) end m	enner es sta	ited. the cause(s)	
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	30. Name and eddress of person BOON P. LIM	who completed cause M. D. 762	of death (ttem 2 2) YORK			1, MD 2	1204				
State Registrar	31. Date filed (Month, Day, Year	32. Re	gistrar's Signatu	re G	Span	6					

DHMH 16 Rev 6/95 61-71-90

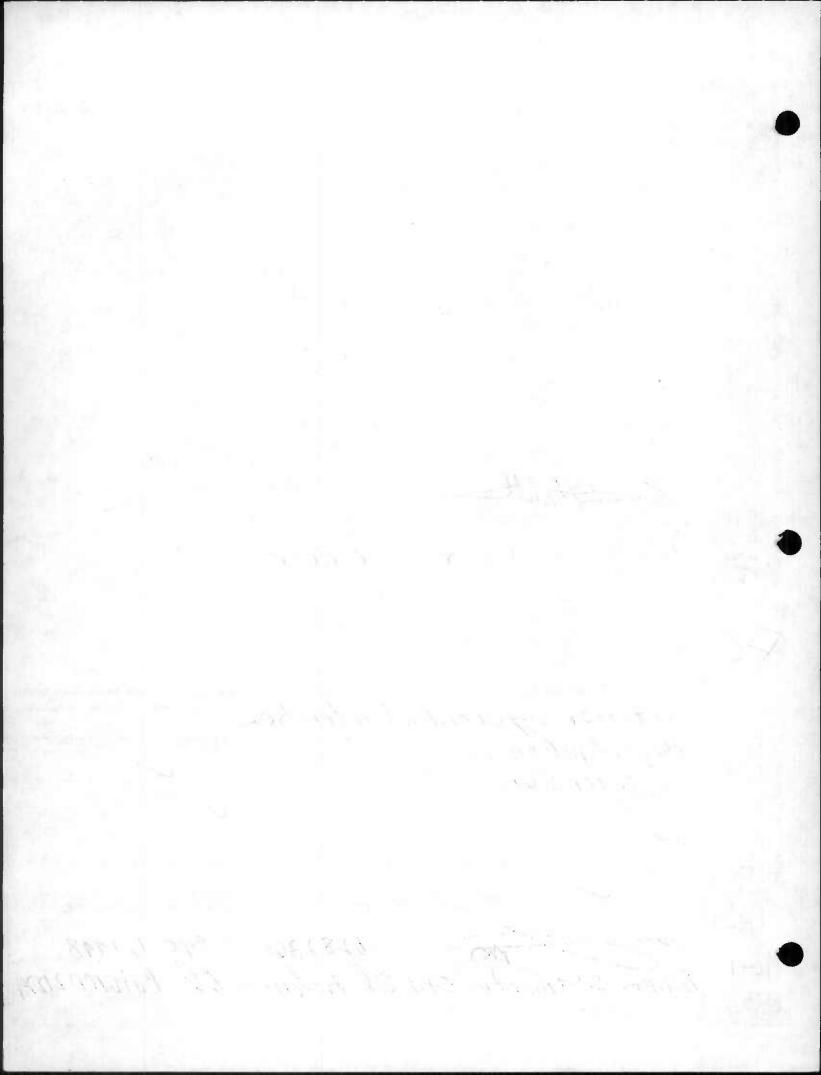
Tompkins

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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is mar		19a. Informent's Neme/Rele	tionship	(Type, Print)			19b. Mailing A	ddress (Street	end Number or	Rural Route Nu	mber, City	or Town, S	Stete, Zip C	Code)
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death INILSON September 3, 1998 **Physician** 21:20 MARIAN · /Medical 4b/City, Town, or Location of Death 4c. County of Death 4e Feclity Name (If not institution, give street end number) Examiner Hospita Baltimore Hopkins If Undar 24 Hrs. 8. If Under 1 5. Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) Yaar 9. Birthplaca (Stata or Foraign **Funeral** 1 M 28 F Months Days Hours 216-36-6468 **Director** Usual Rasidence of Dacedant with the Maryland 10a. Stata 10b. County worle 10c. City, Town or Location 10d. Insida City Limits r than "natural", or items 23s or 28s-f show Ballimore 1 THY S 2 No Director 10f. Zio Coda 10g. Citizan of What Country? 10e. Street and Number Bord Sto 21213 U.S.A. 1131 Funerai death 12. Was Decedant Ever in U,S. Armed Forcas? Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxican, Puerto Rican, etc.) Race - Amaricen Indian, Black, Whita, etc. 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours effer of Department of Health and Mental Hygiene. Important: if frem 27 is marked other than "natural", or frem any injury or other traumatic event, the Medical Exercises page. 1 Navar Marriad 2 Married Yas 2 10 No Specify: Black 1 Yas 2 No Specify: altimore, Maryland 21215-0020 by 3 Widowed 4 Divorced Yaar or Datas: Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Home Elementary/Secondary (0-12) Collega (1-4or 5+) OWN Homemaker 91 NA 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middla, Maidan Sumama) Be Hopkins Blanche Albert 19b. Mailing Addrass (Straat and Number or Ryral Routa Number, City or Town, State, Zip Code)

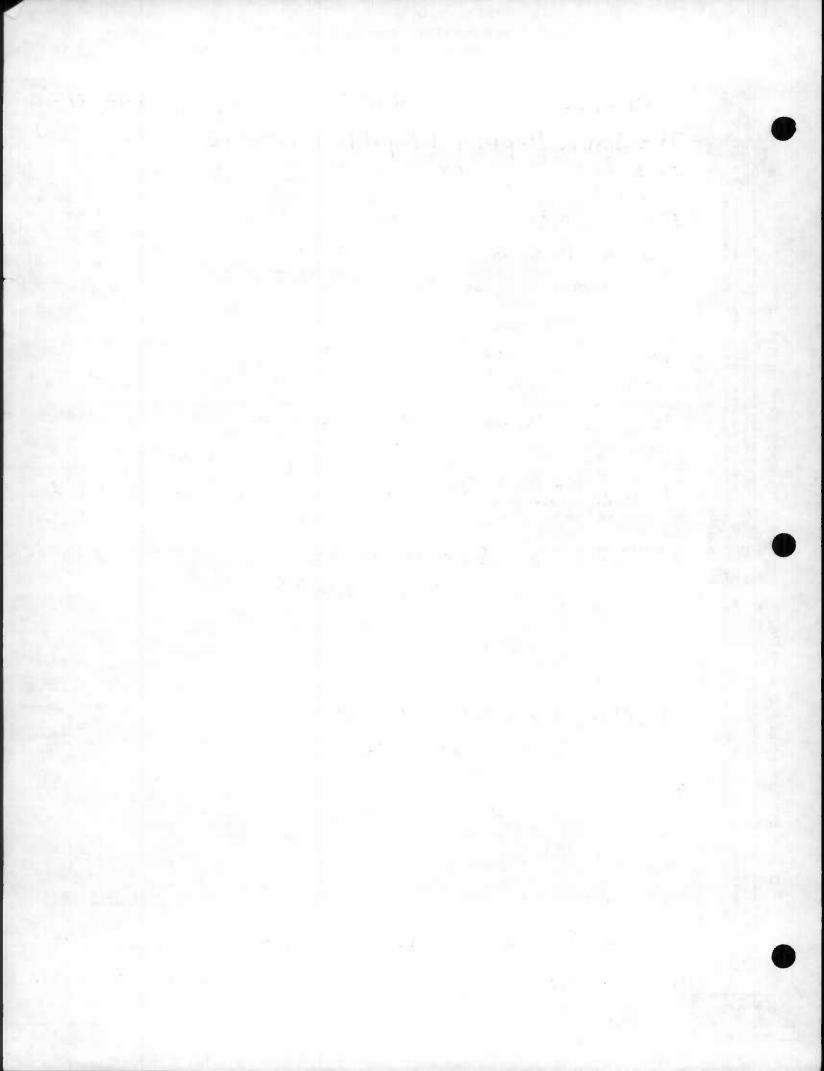
A Round St. o Baltog MD 2/2/3 19a. tnformant's Name/Ralationship (Type, Print) Bond St. n Baltog MD N. Stewart constance 20b. Place of Disposition (Nama of 20c. Locetion - City or Town, Stata Data 20e. Mathod of Disposition ematary, crematory or other placa) 1 Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata Battimore, 4 Donation 5 Other (Spacify) Woodlawn CEN 21. Signature of Funaral Servica Licansee 22. Name and Address of Fecility Es North Are KAST F. H 23a. Part1. Enter the disaesa, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or raspiretory errest shock, or haart failure. List only one ceuse on each line. Approximeta Intarval Between Onsat and Death **Physician** /Medical Immediata Causa (Final seven hous disaase or condition rasulting in daath) Examiner Examiner LABETES Sequantially list conditions, if eny, laading to immadiata causa. Entar Undarlying Cause (Disaasa or injury that initiated avants rasulting in daath) Last Division of Vital Records, P.O. Box 68760, Physician/Medicai the Due to (or as a consequence of): 98 Part It, Other significant conditions contributing to death but not resulting in the underlying couse given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ACUTE RENAL FAILURE Completed by 24b. Wara autopsy findings available prior to GASTROINTESTIMAL BLEENNA 24a. Was an autopsy performed? completion of causa of death? 1 Yas 2 No 1 ☐ Yas 2 No certificate or Attending Physician: after death. Director: After this certific funerel director, 25. Wes casa ratarred to medical axaminar?
1 ☐ Yas 2 ☐ You Be 26. Placa of Death (Chack only one) Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 1 Inpatiant 2 □ ER/Outpatient 3 □ DOA Certification: To 27. Manner of Death 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred 1 Netural 5 Panding invastigation 1 🗌 Yas 2 No 2 Accident 6 Could not be datarminad 3 Suicida 28f. Location (Straat end Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Spacify) 4 Homicide A 24 hou. Hospital 12 Certifying Physician: To the bast of my knowledga, daath occurred et tha time, data and place, and dua to tha causa(s) and manner as steted.
2 Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, daath occurred at the tima, data and place, and dua to the ceuse(s) and manner statad. Medicai 29a. Cartifiar (Check only one) To the To the F 29c. Licanse number 29d. Data signad (Month, Dey, Year) 29b. Signatura and title of certifier RES-000 - Medicine Resident 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print).

Melanie Katzman 600 North Wolfe Sweet Tower 110 Bathmane, Maryland 21287 31. Data filed (Month, Day, Year) 32. Ragistrar's Signatura State

DHMH 16 Rev 6/95

Registrar

SEP 0 8 1998



141.	THION OF	77.TF	S WRIGHT				Ce	rtificate	e of	Death		Reg. No.	, En	/ //	J U
в	Physicia	n	1. Decedent's Name (First, Middle, La	st)						2. Dete of De Month	Day	Year	- 111-	of Death
	/Medic	al	Milton		right	- - 1				4b. City, Town, or L	SEPT.	1, 19		223	7 PM
	Examin	er	4a Facility Name (If no JOHNS HO						'	BALTIMO					
	· · · · · ·		5. Social Security Num			7. Age (In yrs.	last highday	If Undar	1 Year			NA		ana (Stat	or Foreign
	Funeral Director		215-64-	1	∏M 2□F	42	Yrs.	Months	Days	Hours Min.	8. Date of Bir (Month, De		Count		e or Foreign
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	lanylan show	5	MD 10a. State 1	0b. County NA			ty, Town or L altimo								City Limits as 2 □ No
	tha Mar 28a-f st notified	ect	10e. Street and Numb					10f. Zip	Code			10g. Citizen of			
	72 hours after death with the Maryland natural', or items 23s or 28s-1 show dical Exeminat must be notified at	Funeral Director	416 Nor		ver St	reet			224	ŀ		USA		,	
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Maryland 21215-0020	2 should and Men is marke aumatic		19a. Informant's Nam	e/Relationship (Type, Print)		19b. Mail	ng Address	(Street	and Number or Rui	ral Route Numb	er, City or Town	, State, Zip	Code) Z	21224
	DEN B		Cynthia	Har	rison					er Stre					
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Baltimore,	permit. Pagas 1 an Department of Heat Important: If Item 2 any Injury or other Office.		21. Signature of Fune		*							re, Ma			
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attending phy Physiclan/Med To the Hospital or Attending Physicien: The law requires that the death certifica by Completed Be

6 Could not be determined 3 ☐ Suicide 4 ☐ Homicide 29a. Certifier

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Um

111 Penn Street, Baltimore, Maryland 21201

2000 BKK FAYETTE BRUMONE WY 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifie

29c. License number O.C.M.E

29d. Date signed (Month, Day, Year) 2, 1998 SEPT.

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

MARGARION 31. Date filed (Month, Day, Year) 0 8 1998

(Check only one)

32. Registrar's Signature

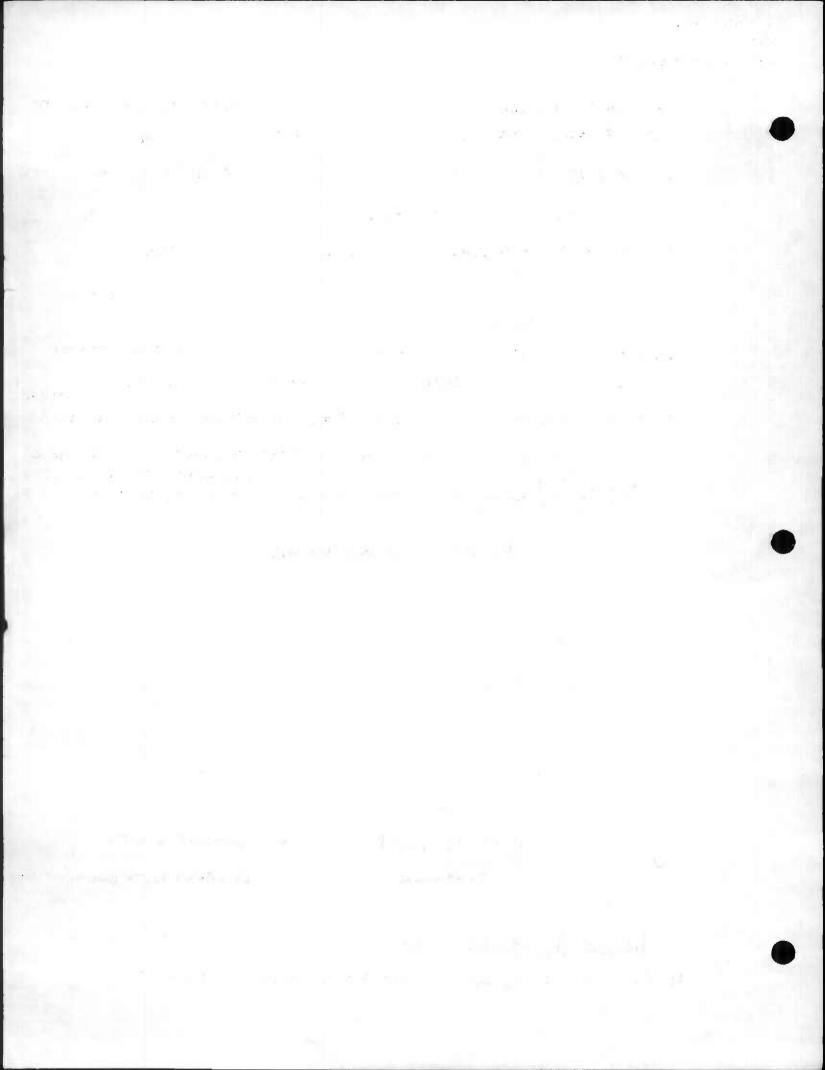
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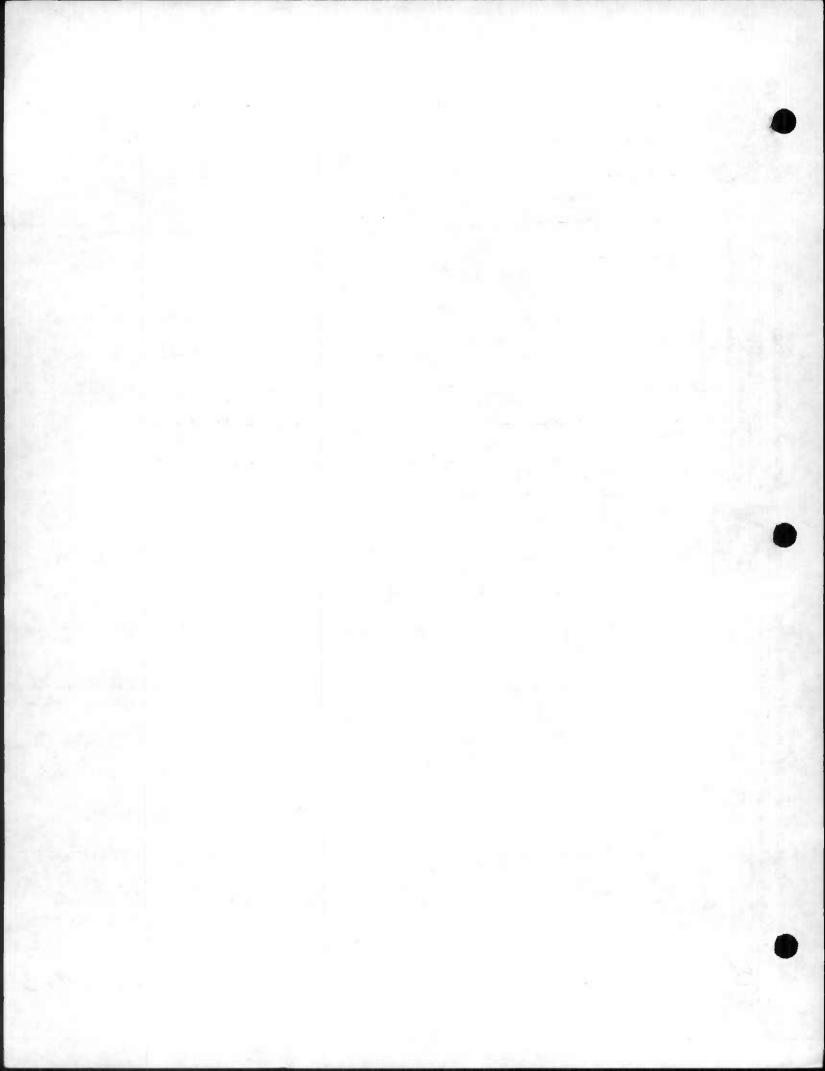
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State of Maryland / Department of Health and Mental Hygiene

	4 Decedent's Nam	a /Clast haidelle f an			Certific		Death	R	eg. No.	} 2	7336
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Funeral Director	5. Social Security N 215-14-9	353	ex 7. ⊠M 2□ F	Age (In yrs. last i	Yrs. Mon	ths Days	Hours Min.	8. Date of Birth (Month, Day July 17		9. Birthpli Count	ace (State or Foreign ry) Md.
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A Sanda Sand	19a. Informant's N	ame/Relationship (7	ype, Print)	15	9b. Mailing Add	ress (Street	and Number or Run	al Route Numbe	r, City or Town,	State, Zip	Code)
C 25 64 F	Mrs. The	resa Wach	ter/wife				Rd. Balt	imore,	Md. 212	34	
Or off	20a. Method of Dis	position Cremation 3	Domewal from Cta	00000	of Disposition ((Name of or other place	ce)	Date	20c. Location -	City or Tov	vn, Stata
Page nent if ny or		5 ☐ Other (Specify			op Serv	rice Co	orp.	/8/98	Towson,	МД	
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Physician /Medical Examiner	Immediate Cause disease or condition resulting in death)	/Final	a.), R	e consequence					71	Interval Between Onset and Death
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that the death cert and by the attending detached for use y Physician/N								1 D Y	as 2 No	3 Prob	ably (Dunknown
ds, de digne											
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Hicer Hicer	25. Was case refer	red to medical									Yes 28 No
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T Sign	1 Yes 2(7)	NO	1 Linps			DOA	42 Nursing Ho	me 5 Resid)
Affects funeral funeral	1/25Natural	5 Pending	28a. Date of li (Month, i	Day Year) 280	Time of Injury	28c. Injury Work		28d. Describe h	ow injury occur	ed	
Attending or death. ector: After by the fune tiffication	2 ☐ Accident 3 ☐ Suicide	investigation 6 Could not be			М		Yes 2 No				
- 125c E	4 ☐ Homicide	determined	208. Place of	Injury - At home, etc. (Specify)	farm, atreet, fac	ctory, office		28f. Location (S City or Tow	treet and Numb n, State)	er or Rurel	Route Number,
C series											
DIVISION To the Hospital or Attendation within 24 hours after dealt. To the Funeral Director: completely filled in by the Medical Certificat	29a. Cartifier (Check only one)	2 Medical Exam	iner; On the basis	of examination	ge, death occur md/or investiga	red at the tin tion, in my o	ne, date and placa, pinion, death occuri	and due to the c red at the time, o	ause(s) and ma late and place,	and due to	ated. the cause(s)
Med Med	29b. Signature and	and of column	and manner	SIRIES /	11	29c. License	a number		9d. Date signe	d (Month)	Day Yearl
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1		11/1/	1	SI		046	750		7-0	77	
121	30. Name and addin	ession person who o	ompleted cause o	death (Item 23a	(Type, Print)		,		,	-	
(4)	AYMA	- FATI	41 AF	KAD	30	66	INCOI	1 AV	12,44	THER	Y, 1/2 MD
State	31. Date filed (Mon	th, Day, Year)	32. Regi	strar'a Signature							5
Registrar		SED 0 8 10	90 6	and a proper	la						



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month Des **Physician** WIDEMAN 29th 1998 7.35 PM FLOYD August /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) Examiner NIA MEDICAL DALTIMORE LIBERTY ENTER If Under 1 Year 5. Social Security Number If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex **Funeral** Deys Hours Months 10 M 20 F 90 250.26.3648 Director Usual Residence of Decedent permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiana. Important: If Item 27 is marked other than "natural", or items 23a or 28s-4 show any injury or other traumatic event, the Madical Exempted. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No BALTIMORE NIA Director MO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Eyer in U.S. 3506 21216 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, atc. 11. Maritai Status Armed Forces?
1 ☐ Yes 2 ☑ No 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates: Specify: BLACK P 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) SANITATION WORKER UTH GRADE NIA **BRYANS** RASH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumame) THOMAS WIDEMAN ALICE TLOYO 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) LANE, GASTONIA, NC ZOUSE

Date 20c. Location - City or Town, State MINNIE SMITH 3120 CRESENT AUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from Stete 9/3/98 METRO CREMATORY BALTO. MO 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Ferrice Licensee VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL' PIKE, BALTO. 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart inform. List only one cause on each line. Approximate Interval Batween Onset and Death **Physician** /Medical Immediate Causa (Final 30 Days Overwhelming disaasa or condition resulting in death) Examiner Due to (or as a consequence of) Examiner 30 Days neumonia attanding physician and for usa as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Tubular Acute Necrosis Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as a consequence of): 14days ungemia signed by the a 23b. Did tobacco usa contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 3 □ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No þ 24b. Wara autopsy findings available prior to completion of cause of death? should I 24a. Was an autopsy performed? Completed his cartificata has b 1 Yes 2 No Yes 2 🗆 No or Attending Physician: Be 25. Was cese referred to medicel examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury (Month, Day Year) funaral 27. Mangfer of Death 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? Certification: Aftar t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No daath. Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or A within 24 hours after To the Funeral Directomplately filled in by 4 Homicide aftar 1 Certifying Phyalcian: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signature and title of cedifier Kemanllogur August zath 1998 Attending D38993 and addrass of person who complated ceusa of death (Itam 23a) (Type, Print) Nam

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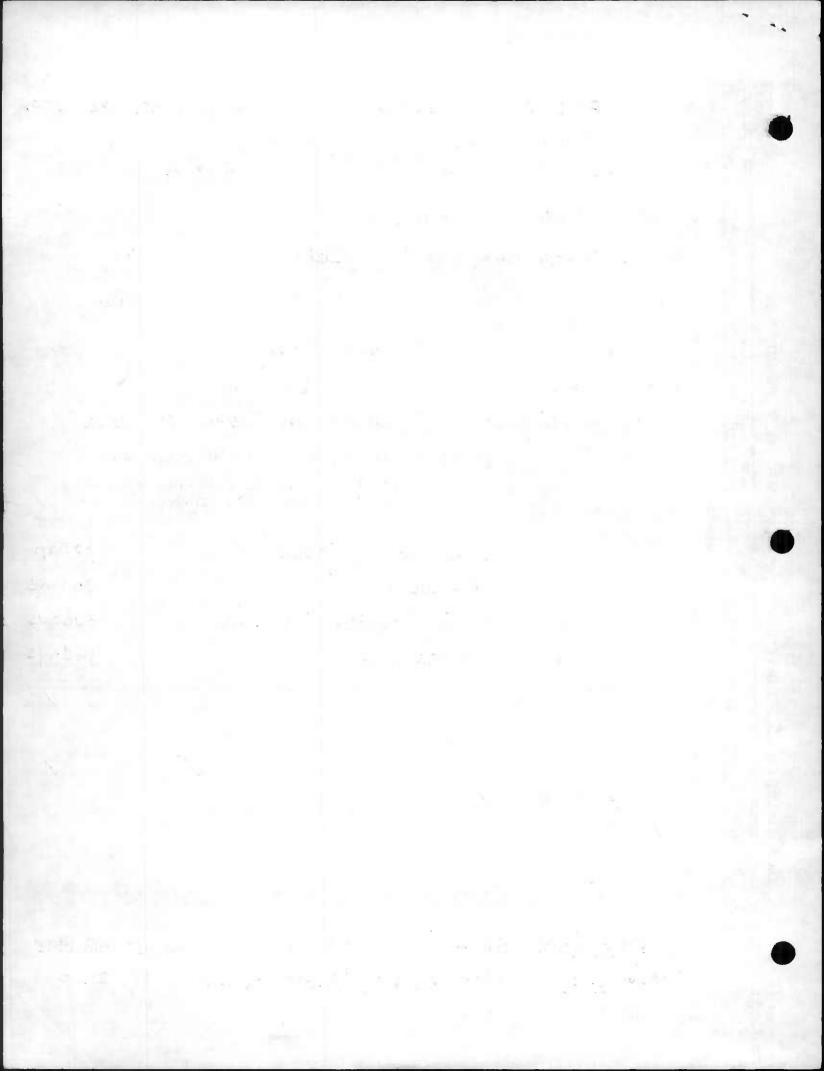
32. Registrar's Signature

Baltimore WV 21215

DHMH 16 Rav 6/95

State Registrar awanloen

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Physicia /Medic Examin		MATIET O AUGUS										
	201	MABEL S. ATK						Aug 23	, 1998	Year	1:45	pm
		4e. Fecility Neme (If not institution,		er)			4b. City, Town, or L	ocation of Deeth	4c. County	of Deeth		
		CUMBERLAND NUF	SING HOME				CUMBERLA	ND	ALLEG	ANY		
Funeral Director		5. Sociel Security Number 214–20–1133 Usuel Residence of Decedent	Sex 1 □ M 2 F 7. /	Age (In yrs. 89	lest birthday) Yrs.	Months Deys	If Un r 2 Hrs. Hours Min.	8. Date of Birth (Month, Dey Dec 7	7 Yeer) 1908	9. Birthp Court MD	plece (Stete of htry)	or Foi
8 m		10a. State 10b. County		10c. Ci	ty, Town or Loc	ation				1	0d. Inside C	ltv Lir
23e or 28a-f show	to	MD Allegar	nv		Cumber	land					1X Yes	
r 28a	Director	10e. Street end Number	-			10f. Zip Code		1	log. Citizen of W	het Cour	ntry?	
23e	a D	60 Boone Street				21502	2		USA	A		
ar, or items	by Funeral	11. Marital Status 1 □ Never Married 2 □ Merried 3 ☑ Widowed 4 □ Divorced	12. Was Deceder Armed Forces 1 Yes 2 If Yes, Give Yeer or Detes	s?] No	lf lf	/as Decedent of H Yes, specity Cube	lispenic Origin? (Sp en, Mexicen, Puerto Specify:	pecify Yes or No- Rican, etc.)		k, White,	ean Indien, etc. white	
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the fu	catl	2 Accident investigation	on			M 1	Yes 2□No					
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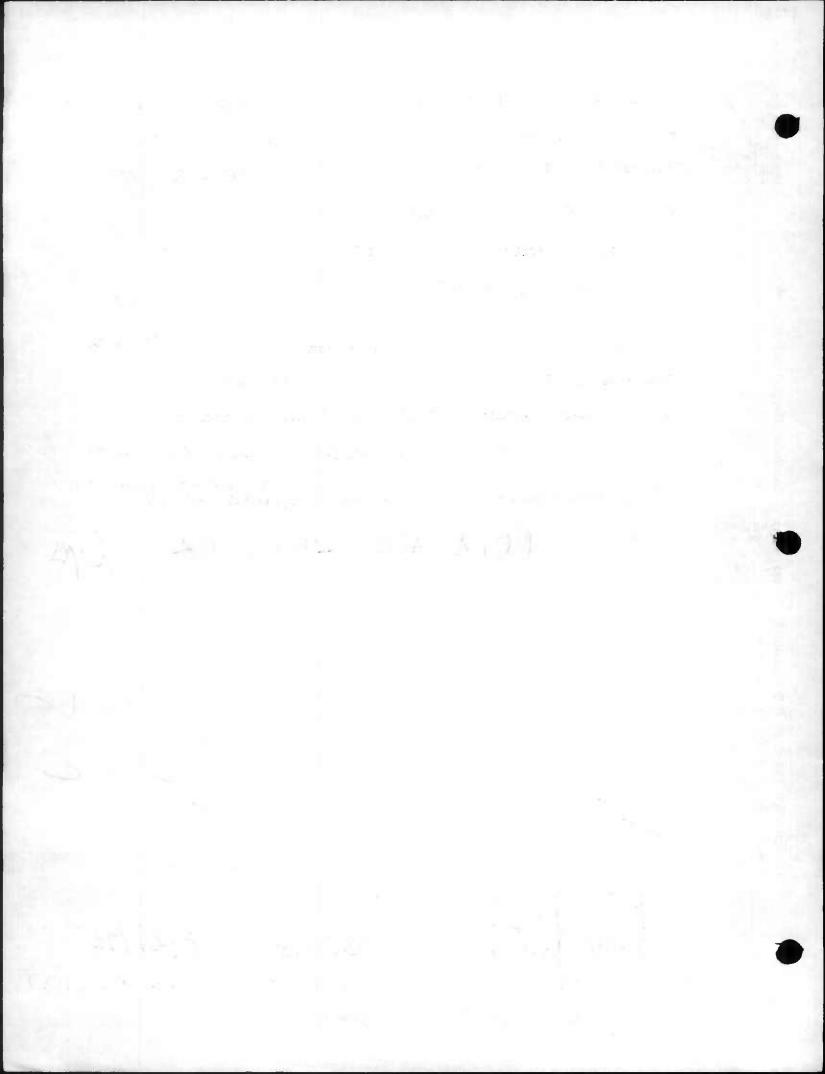
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						Certificate of			Reg. No.	7339
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	/Medi Examir	al	RICHARD 4e. Facility Neme (If not institution,	SIDNEY		ALLISON	4b. City, Town, or I	August	20 1998	12:15 p.m.
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	pur *		Usuei Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				1
	h the Marylan r 28a-1 ahow	٥٢			roc. Oity, Town		المدادية			10d. Inside City Limits 1 ☐ Yes 2 🕱 No
	158 100 100 100 100 100 100 100 100 100 10	Director	Maryland 10e. Street and Number	Calvert		10f. Zlp Code	derland	1	10g. Citizen of What Co	
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020	filed within 72 hours efter death with the Maryland Hygiene. ther than "naturel", or items 23s or 28s-4 show thit, the Medical Examiner must be notified at	by Funerai	11. Marital Status 1 □ Never Merried 2 □ Married 3 □ Widowed 4 ☑ Divorced	12. Was Decedent Ev Armed Forces?	er in U,S.	13. Was Decedent of H If Yes, specify Cubs		pecify Yes or No- o Rican, etc.)	14. Race - Ame Bleck, White Specify:	
Maryland 21215-0020	in 72 hours n "natural", fedical Ex	Completed	15. Decedent's (Specify only highest of	Education trade completed)		Decedent's Usual Occup Give kind of work done life. DO NOT use retired	during most of war	king	16b. Kind of Business	
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68760,	Physician Medical Examine be supported by the principle of the principle	Medical Examiner	Immediate Cause (Final disease or condition resulting In death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Di	e to (or as a co	nsequence of):	lex	مناك	seare	Onset and Death A free
of Vitai Records, P.O. Box	The law requires that the death certificate has been signed by the ettending page 2 should be detached for use as	Completed by Physician/M	Pert II. Other significant conditions Muhal R Sieness C		not resulting in the following in the fo	the underlying cause give April	Ponin Part I.	1 De de 24a. Wes perío	Yes 2 No 3 P an autopsy 24b.	vo the cause of death? robably 4 Unknown Were autopsy findings available prior to admipletion of cause of death?
itai	iclan: The certificate h	Be Co	25. Was case referred to medical				26. Plece of Dec	1 Check only o	1.30	1 ☐ Yes 2 ☐ No
Division of V	To the Hospital or Attending Physician: which 24 hours steft deads as the fundation. To the Funeral Director: After this certified completely filled in by the funeral director,	Certification: To	examiner? 1 Yes 2 27. Mann Death 5 Pending 2 Accident investiget 3 Suicide 6 Could not 4 Homlolde determine	be Disease living	(ear) 28b. Tir	ne of 28c. Injur	4 Ly Nersing H	28d. Describe h	dence 6 □Othar (Spenow Injury occurred Street and Number or R	
۵	Hospital o	edicai Cer	29a. Certifier (Check only one)	thyalclan: To the best of a	my knowledge, o	death occurred at the tir or investigation, in my o	ne, dete and placa pinion, death occu	, and due to the	cause(s) and manner as	s stated. to the cause(s)
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		Decedent's Name (First,					rtificate of	Douth	2. Dete of Dee		Vaar	3. Time of Dec
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Funeral Director		5. Social Security Number 214–26–0627		Sex ¶X∏M 2□F	7. Age (In yr 68	rs. last birthday, Yrs.	Months Deys			7 Year) 1930	9. Birthp Coun	elece (Stete or Fo
show	7.	Usual Residence of Deceder 10a. Stete 10b. C MD Carr				City, Town or L					1	0d. Inside City Li
23a or 28a-f should be notified at	Funeral Director	10e. Street end Number 2032 Feeser		North			10f. Zip Code 21787			10g. Citizen of	Whet Coun	1 □ Yes 2 to
or items	by	11. Marital Status 1 Never Merried 2 3 Widowed 4 Div	-	12. Was Dece Armed Fo 17 Yes If Yes, Giv Year or D	rces? 2 □ No 19	47-	Was Decedent of If Yes, specify Cu	ben, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Ra Ble	ce - Americ ck, White,	etc.
n 'natural',	Completed	(Specify only		ede completed)		16e. Dece	dent's Usuel Occu kind of work done DO NOT use retir	during most of w	orking	16b. Kind of B	lusiness/inc	dustry
her than nt, the M	Com	Elementary/Secondery (0 8		College (1	-4or 5+)		stos wor	ker	Time Afiddle	manufa		ng
and Mentel Hygie s marked other t umatic event, th	To Be	Michael A. A	Altho	ff					eme (First, Middle, a Wagner	Maiden Sumei	ne)	
it of Health and Mentel Hyg If Itam 27 is marked other or other traumatic event,		19e. Informent's Name/Rei Mrs. Ruth A	etlonship (Altho	Type, Print) ff (spo	use)	19b. Meili 2032	ng Address <i>(Stree</i> Feeser R	d. N., T	aneytown,	Md 21	, Stete, Zip 787	Code)
Department of Health and Important: If itam 27 is ma any injury or other traumonce.		20e. Method of Disposition 1 Burial 2 Creme 4 Donation 5 Oth			Ctata	cemetery, cre	osition (Neme of metory or other place W Memori	al	Date 8-25-98	20c. Location Sykesvi		
Departmen Important: any injury once.		21. Signeture of Funeral Se			×+		2. Neme end Addi	H	aight Fur sville, M			Chapel
aminer		disease or condition resulting in death)		θ.	1 1							10 10 -1
physician and the buriel-transit	dicai Examiner	Sequentielly list conditions, if eny, iseding to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest	{	b. ————————————————————————————————————	Due to	(or as e consector es	quence of):	Lunc		7		حالان
O (0	sician/Medical Examiner	Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events	l	b. — c. — d. — ontributing to de	Due to	(or as e consection of the con	quence of): quence of):			obacco use co	ontribute to	OYA
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ner this certificate has been signed by the attending funeral director, page 2 should be detached for use a	Certification: To Be Completed by Physician/M	Sequentially list conditions, if any, leading to immediate course. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Lest Pert II. Other significent co 25. Wes cese referred to mexaminer? 1 Yes 2 27. Manuar Death 1 Homicide 29a. Certifier	edicel edicel	Hospitel: 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Due to Due to Due to patient 2[of tnjury h, Dey Year) of Injury - At 19, etc. (Spec	(or as e consection of the con	quence of): quenc	26. Place of De her: 4 \(\text{ Nursing ry et rik?} \)	23b. Did to 1	es 2 No en eutopsy med? es 2 No en eutopsy med? es 2 No en eutopsy med? en es 2 No en eutopsy med? en eutopsy med eutopsy med? en eutopsy med eutopsy	3 Prob 24b. We everyone of control of the control o	ore eutopsy finding elebie prior to impletion of cause deeth? Yes Control Houte Number, eled.
ne zer notes aner uean. In ternoral Director, After this certificate has been signed by the attending pletely filled in by the funeral director, page 2 should be detached for use a	ledical Certification: To Be Completed by Physician/M	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Pert II. Other significent content of the content of the cause of the content of the cause of th	edicel ending investigation could not be elemented	Hospitel: 1 1 28e. Detection (Mont. 1 28e. Piece building yelclan: To the bainer: On the ba	Due to Due to Due to patient 2[of tnjury h, Dey Year) of Injury - At 19, etc. (Spec	(or as e consection of the con	quence of): quenc	26. Place of De her: 4□ Nursing iny et ink? 1 Yes 2□ No ime, date end placopinion, death occopinion, death occopinion, death occopinion.	23b. Did to 1 Y 24e. Wes e perfor 1 Y 24e. Wes e perfor 24e. Wes e perfor 1 Y 28d. Describe he 28f. Location (S City or Town 28f. and due to the curred et the time, d	es 2 No en eutopsy med? es 2 No en eutopsy med? es 2 No en eutopsy med? en es 2 No en eutopsy med? en eutopsy med eutopsy med? en eutopsy med eutopsy	3 Prob	peably Unk ere eutopsy findin elieble prior to mpletion of cause deeth? Yes Quant



State of Maryland / Department of Health and Mental Hygiene | | |

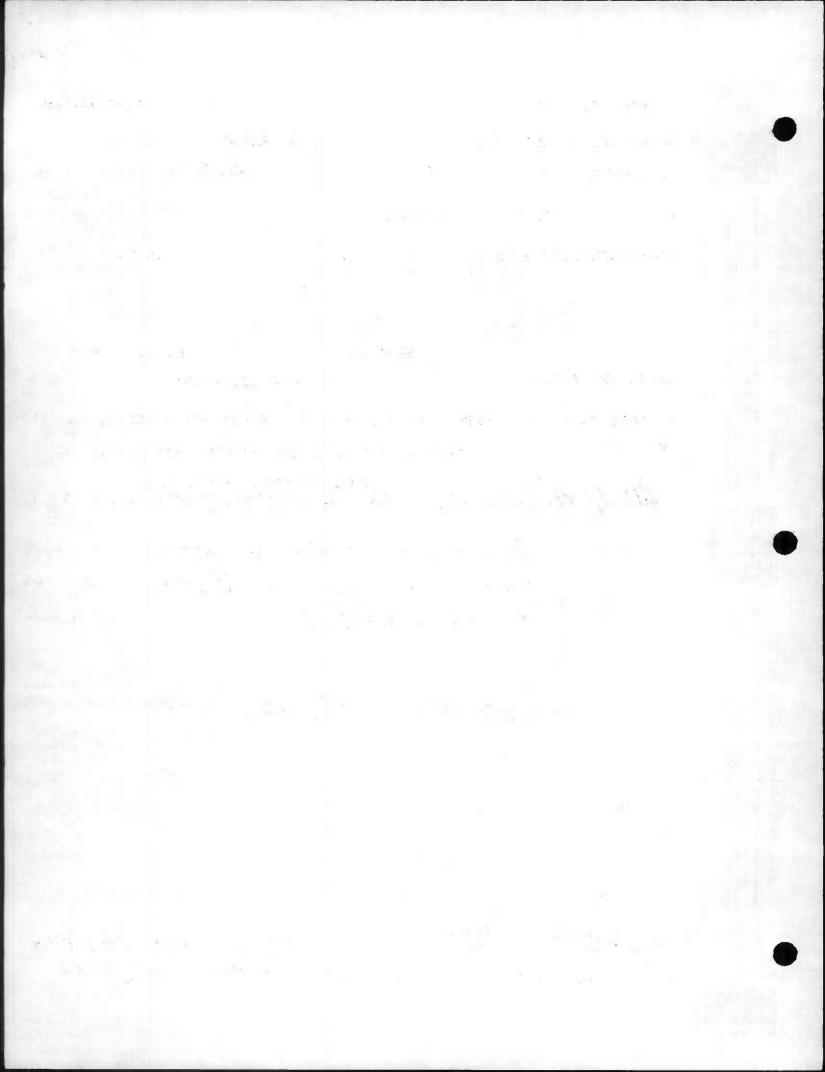
Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath 3. Time of Deeth Month **Physician** 10:40AM JOSEPH F. AUGUST 20, 1998 BRAGA /Medical 4b. City, Town, or Location of Daath 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner SACRED HEART HOSPITAL CUMBERLAND ALLEGANY If Undar 1 Yaar 8. Data of Birth (Month, Day, Year) NOV . 27, 1910 Birthplaca (Stata or Foraign Country) 5. Social Sacurity Number 7. Aga (In yrs. last birthday) **Funeral** Days Months 1 € M 2 □ F Yrs. 87 Director 004-07-7923 MASSACHUSETTS Usual Rasidanca of Dacedani with the Marylend 10a. Stata 10c. City, Town or Location 10d. fnsida City Limits 10b. County worle r than "naturel", or items 23a or 28a-f ehor Yas 2 No MD ALLEGANY CUMBERLAND Directo 10e Street and Number 10f. Zip Coda 10g. Citizan of What Country? 1105 FREDERICK STREET 21502 U.S.A. Funerai death Was Decadant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedant Evar In U,S. Armed Forcas? 11. Marital Status filed within 72 hours eftar Hygiene. other than "naturel", or ite 1 Navar Marriad 2 Married 1 ☐ Yas 2 🛣 No If Yes, Giva altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specity: WHITE þ 3 ☐ Widowad 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Dacadant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) 12 RETAIL STORE i. Pages 1 and 2 should be filed witnest of Health and Mental Hygie tant: If Item 27 is marked other tigury or other traumatic event, III MANAGER 18. Mothar's Nama (First, Middla, Meidan Sumama) 17. Fathar's Nama (First, Middla, Last) Be MANUEL F. BRAGA FRANCES ARUDA 0 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) 1105 FREDERICK STREET, CUMBERLAND, MD 21502 M. LORETTA BRAGA / WIFE 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1X Buriel 2 ☐ Cramation 3 ☐ Ramoval from Stata permit. Page Department of Important: If any Injury or once. SS. PETER & PAUL CEMETERY 8/24/98 CUMBERLAND, MD 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funaral Sarvice Licania 22. Nema and Addrass of Facility UPCHURCH FUNERAL HOME, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each tine. 202 GREENE STREET, CUMBERLAND, MD 21502 Approximete Interval Batween Onsat and Death **Physician** /Medicai Immadlate Ceuse (Final Miscons KNUWN disaasa or condition rasulting in daath) **Examiner** Dua to (or as a consequence of): Examiner NKNOWW ASHANOTO OLONDRY that the death certificata be executed Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disease or Injury that initiated avants rasulting in death) Last physician and s the burial-tran Dua to (or as a consaquance of): NULL P.O. Box 68760. Physician/Medical Dua to (or as a consequence of) for use es signed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco uss contributa to the cause of death? 1 Yes ANO 3 Probably 4 Unknown Records, þ 24b. Wera autopsy findings available prior to completion of cause of death? should should 24a. Wes en autopsy performed? Completed page 2 1 U Yas 2 2 No PO No 1 ☐ Yas cartificata Division of Vital Attending Physician: director, 25. Was casa rafarrad to medical axaminar? Be 26. Piece of Deeth (Check only ona) Othar: 4 ☐ Nursing Homa 5 ☐ Rasidanca 6 ☐ Othar (Specify) 1 Yes No 2 1 ☐ Inpatient 20€R/Outpatiant 3 ☐ DOA this funeral 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Natural 5 Pending s eftar deeth.

I Director: Aft
d in by the fur 1 ☐ Yas 2 ☐ No invastigation 2 Accidant 6 Could not be dataminad n 24 hours efter der ne Funerel Directo bletaly filled in by th 3 Suicida 28a. Place of Injury - At homa, farm, straet, factory, office building, atc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 Homicida ò Hospital 29a. Cartifiar 🕵 Cartifying Phyalcian: To tha bast of my knowledga, death occurred at tha tima, data and pleca, and dua to tha causa(s) end mennar as stated. Medicai To the Hosp within 24 ho To the Fune completaly f 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. (Check only one) 29d. Data signed (Month, Dey, Year) 29b. Signature and file of certilier 29c. Licansa number 8 **AUGUST** PARRICISM 30. Name and eddress of person who completed cause of deeth (ttem 23e) (Type, Print) VERD MY, MJC. SULLE anostan 938 avenua

State Registrar

31. Data filad (Month, Day, Yaar) AUG 2 6 1998

32. Begistrar's Signature



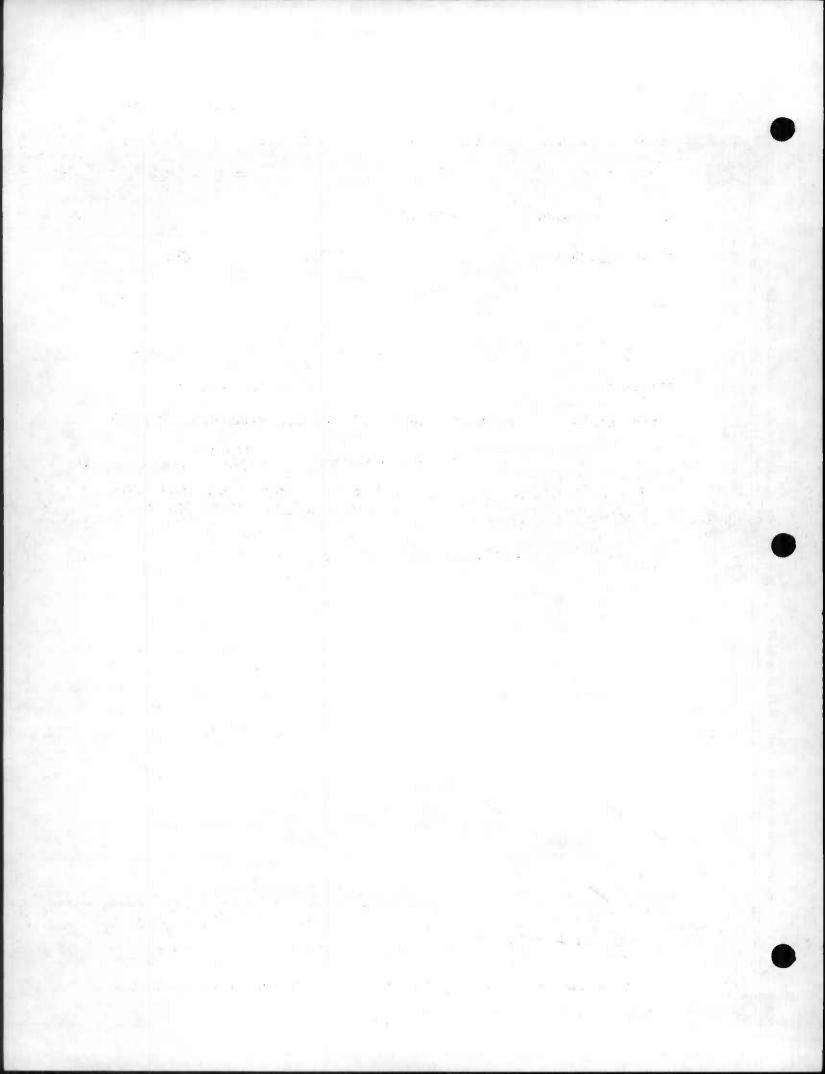
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Time of Death 1. Decedant's Nama (First, Middla, Last) 2. Date of Death **Physician** 9:49 AM 20 RALPH PENGELLY BENDER, SR. AUGUST 1998 /Medical 4b. City, Town, or Location of Daath 4c. County of Deeth 4a Facility Nama (If not Institution, giva straat and number) Examiner ALLEGANY SACRED HEART HOSPITAL CUMBERLAND If Under 1 Yaer | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** Months Days Hours 1₩ 2□F 87 Yrs. APRIL 28,1910 MARYLAND Director 216-14-1885 Usual Rasidanca of Dacadant with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits r than "naturel", or items 23e or 28a-f ehow the Medical Examiner must be notified at 1 Yas 2 □ No Director MARYLAND ALLEGANY FROSTBURG 10f. Zip Coda 10g, Citizan of What Country? 10e. Street end Number 21532 U.S. 5 STANDISH STREET Funeral death Was Decedant of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuben, Mexican, Puarto Rican, atc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - Amarican Indian. 11. Marital Status Black, Whita, atc. filed within 72 hours after 1 Nevar Marriad 2 Married 1 Yas 2 No 0 1 ☐ Yas 2 X No Specify: Specify: p 3 Widowed 4 Divorcad WHITE Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collaga (1-4or 5+) VICE PRESIDENT BANK permit. Pagas 1 and 2 should be file.
Department of Health and Mantai Hyg important: If Nem 27 is marked other eny injury or other traument. 7 Is marked other traumatic event, 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maidan Sumama) Be 2 ALBERT BENDER KATHERINE (PENGELLY) BENDER 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Raletionship (Type, Print) RALPH P. BENDER, JR. 5 STANDISH STREET, FROSTBURG, MD 21532 altimore, 20b. Place of Disposition (Name of camatary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramovel from Stata 4 ☐ Donation 5 ☐ Other (Specify) ST. MICHAEL'S CEMETERY 8/22/98 FROSTBURG, MD 21. Signeture of Funaral Sarvice Licansaa 22. Nama and Addrass of Fecility
SOWERS FUNERAL HOME, P.A. 60 WEST MAIN ST., FROSTBURG, MD 21532 Approximata Interval Between Onsat and Death plications thet causad tha deeth. Do not enter the moda of dying, such as cardiac or raspiratory arrast, one causa on each line. **Physician** /Medical Immediata Causa (Final disease or condition resulting in death) Examiner Examiner stronteste that the death certificate be executed physicien and s the buriel-trans Sequentially list conditions, if any, laading to immadiate causa. Enter Underlying Causa (Diseasa or injury that initiated evants rasulting in daeth) Last Due to (or as e consequence of) P.O. Box 68760, Physician/Medical Dua to (or as a consequence of): signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? colon, abdominil 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, ð 24b. Wara autopsy findings available prior to complation of cause of daeth? 24a. Was an autopsy Completed s cartificata hes b director, paga 2 s 1 Yes 2 No 1 ☐ Yas 2 ☐ No or Attending Physician: after death. Director: After this cartific Be 25. Was case referred to medical examiner? 26. Piece of Death (Chack only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 1 Yas 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA funerai 28e. Date of Injury (Month, Day Year) 27, Mannar of Death 28d. Dascribe how injury occurred 28b. Time of 28c. Injury et Work? Certification: 1 Natural 5 Pending 1 Tyas 2 No 2 Accident Invastigation n 24 hours after des re Funeral Director clataly filled in by the 3 Suicida 6 Could not be datermined 28f. Location (Straet and Number or Rural Routa Number, City or Town, Stata) Place of Injury - At home, farm, straet, factory, office building, etc. (Specify) 4 Homicide Certifying Physicien: To the best of my knowledga, daath occurred et the time, data and place, and dua to the causa(s) and mannar as stated.

| Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, daath occurred at the time, date and place, and due to the causa(s) and mannar stated. Medical 29a. Cartifiar To the Hosp within 24 ho To the Fune complately f (Check only one) 29c. Licansa number 29d. Data signad (Month, Day, Year) 29b. Signature end titla of certifiar mo D12532 12 AUGUST 21, 1998 30. Nama and eddress of person who completed causa of death (Itam 23e) (Type, Print) my 912 Seton Drive, Cumberland, MD 21502 George M. Breza M.D. 32. Registrar's Signature 31. Data filed Month, Day, Year) AUG 2 5 1998 State Registrar

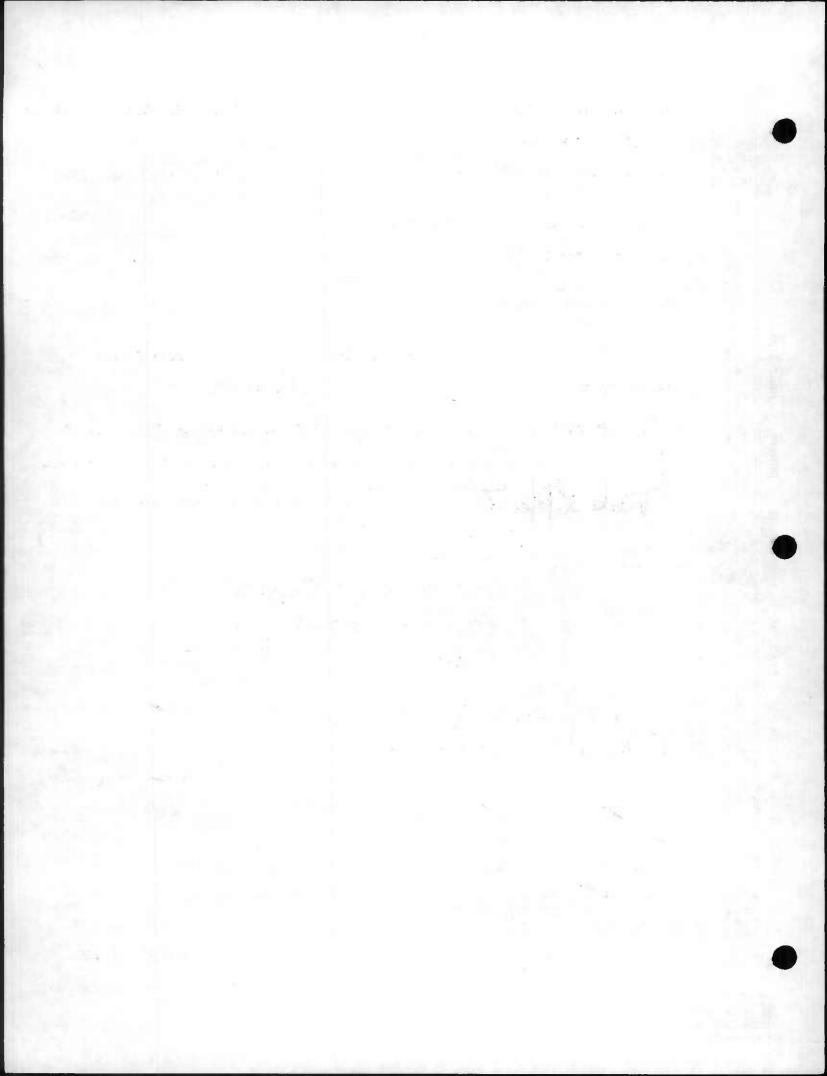
منجورة		(and)		Certific	cate o	or Death	0.000	Reg. No.		2 Time of Dear
/sician	Decedent's Name (First, Middle,	Last)					2. Date of D Month	eath Day	Year	3. Time of Death
ledical	Ray I. Breigh					1 . 65 -	August			6:38 p.m.
aminer	4a Facility Nama (If not institution,	give streat and number	er)			4b. City, Town, or I	Location of Dea	th 4c. County	of Death	
	Memorial Hospita 5. Social Security Number	1 & Medica	1 Cen	ter HI	Inder 1 Y	Cumberlan aar If Under 24 Hrs.	d 8. Date of B	Allega	ny	ace (State or Foreig
eral		X□M 2□F		Yrs. Mor		ays Hours Min.	(Month, D	ay, Year)	Count	try)
tor	217-18-4320 Usual Residence of Decedent		78				May 2	2, 1920	MD	
	10a. Stata 10b. County		10c. Cit	y, Town or Location	1				10	0d. Insida City Limits
by Funeral Director	WV Mineral			Ridgeley						1 ☐ Yes 🏌 No
Director	10e. Street and Number				f. Zip Co	de		10g. Citizen of V	What Count	try?
	Route 3 Box 41				267	53		USA		
Funeral	11. Marital Status	12. Was Decede		S. 13. Was D		of Hispanic Origin? (S Cuban, Maxican, Puert	pecify Yas or N		a - America	
Ē	1 ☐ Never Married X ☐ Marrie	Armed Force					o Alcan, etc.)		ck, White, e	etc.
by	3 ☐ Widowed 4 ☐ Divorcad	If Yes, Give Yaar or Data	3:	1 1 1	es Xॄ□	No Specify:		Specify		nite
Completed	15. Decedent's (Specify only highest	Education grade completed)		16e. Decedent's	of work di	one during most of wor	rkina	16b. Kind of Bi		
nple	Elementary/Secondary (0-12)	College (1-4d		life. DO NO	OT usa re	etired)				
Cor	12			Retired G	lass			PPG Inc		ies
Be	17. Father's Name (First, Middle, La					18. Mother's Nar	ne (First, Middi	e, Maiden Suman	na)	
To	John Breighner					Susie (
	19a. Informant's Neme/Relationship					reet and Number or Ru		ber, City or Town,	State, Zip	Code)
pnce.	Norma L. Breigh	nerwife	005 5			41; Ridgel		26753	Oh. a. Ta	State
	20a. Method of Disposition **Disposition 3 **Disposition 3	B □Removal from Sta	te ZUB. F	Place of Disposition emetery, crematory	orother	placa)	Date	20c. Location -	City or To	wn, State
	4 Donation 5 Other (Spe			lcrest Me	-		08/26	Cumberl	and,	MD
The state of the s	21. Signature of Funeral Service Li	censee	M.			ddress of Facility lli Funera	Home	DΛ		
5	Yudadas)	1. Dray	olsh				21502	Γ.Λ.		
	23a. Pert1. Enter the diseasa, of conshock, or heart failure. List or	omplications that cause on each	ed the deat	h. Do not antar tha	mode of	dying, such es cardia	or respiratory	arrest,		Approximate Interval Batween
ian		,							+	Onsat and Deeth
cal	Immediate Cause (Final disease or condition	Intrac	table	congesti	ve c	ardiac fai	lure		1	15 months
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Examiner	Sequentially list conditions, if any, leading to immediate	В.	Due to (d	or as a consequence	of):					
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dicai	that initiated events rasulting in death) Last	G	Due to (o	r as a consequance	of):					
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an		0								
Physician/Me	Part II. Other significent conditions	s contributing to deat	but not res	ulting in the underly	ing caus	e given in Pert I.	23b. Di	d tobacco use co	ntribute to	the cause of death
							1[Yes 2A No	3 Prob	bably 4 Unknow
by									T 045 146	
ted							24a. We	s an eutopsy formed?	ava	ere eutopsy findings allable prior to mpletion of cause
									of c	deeth?
6							1	Yas 2. No	1□	Yes 2□ No
Comp	25. Was case referred to medical					26. Place of De	ath (Check only	one)		
Сотр		Hospital:	atiant 2	ER/Outpatient 3[Home 5□Re	sidenca 6 Oth	ner (Specify	y)
Be	examiner?	1 DE IND	njury	28b. Time of Injury		Injury at Work?	28d. Describe	how Injury occur	red	
To Be	examiner? 1 Yas 2021No 27. Manner of Death	28a. Date of I	Day Year)	B. 6		1 ☐ Yes 2 ☐ No				
To Be	examiner? 1 Yas 2 No 27. Manner of Death 1 Natural 5 Pending investiga	28a. Date of I (Month,	Day Year)	М				(Canadanal Abra)	ber or Rura	it Route Number,
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Certification: To Be	examiner? 1	28a. Date of I (Month, tition by be ed 28e. Placa of building, Physician: To the be	Injury - At hetc. (Specif	ome, farm, street, fa y) wledge, death occu	rred at th	he time, dete and place	City or T	own, State) e cause(s) and m	enner as st	tated.
edicai Certification: To Be	examiner? 1 Yas 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only 2 Medical Ex	28a. Date of I (Month, tition by be ed 28e. Placa of building, Physician: To the be	Injury - At hetc. (Special	ome, farm, street, fa y) wledge, death occu	etion, in	ne time, dete and place my opinion, deeth occu	City or T	e cause(s) and mea, date end plece,	and due to	the ceuse(s)
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	1. Decedent's Name (First, Middle, Last)	Reg. No. 2 / 3 L L
cian lical	HARRY BEEMAN	August 14, 1998 12:20 pm
r	Memorial Hospital & Medical Center Cumber	
	213-01-5457 1⊠ M 2□ F 87 Yrs. Months Deys Hours I	Hrs. 8. Date of Birth (Month, Day, Year) July 9, 1911 9. Birthplace (State or Foreig Country) MD
	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits 1 12 Yes 2 No
	MD Allegany Lonaconing 106. Street end Number 107. Zip Code	10g. Citizen of What Country?
	60 E. Main Street 21539	USA
	11. Marital Status 12. Was Decedent Evar in U.S.	n? (Specify Yes or No- Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: White
	15. Decedent's Education (Specify only highest grade completed) Elamantary/Secondary (0-12) Collega (1-4or 5+) Labor	of working 16b. Kind of Business/Industry Fabric
	17. Father's Name (First, Middle, Last) 18. Mother's	s Name (First, Middle, Maldan Surname)
		Belle Clise or Rural Route Number, City or Town, Stata, Zip Coda)
		Lonaconing, MD 21539
	20a. Method of Disposition 1 🔀 Burial 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Oak Hill Cemetery	Aug. 16 Lonaconing, MD
Completed by rugsicial (medical Examine)	23a. Part Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as care shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition rasulting in death) a. AdenoCarcinoma Colorectal Dua to (or as a consequence of): b. Due to (or as e consequence of): a. Due to (or es e consequence of): d. Due to (or es e consequence of):	Six Years
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacco use contribute to the cause of death
		24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
200	25. Was case raferred to medical 26. Placa of	of Daath (Check only one)
2	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursi 27. Manner of Death 1 Natural 2 Accidant 3 Suicide 4 Homicida Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursi 2 ER/Outpatient 3 DOA Other: 4 Nursi 4 Nursi 28e. Data of Injury 4 North, Day Year) 28e. Place of Injury - At home, farm, street, factory, office	28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)
edical cer unication.	29a. Certifier (Check only Certifying Physician: To the bast of my knowledge, death occurred at the time, date and process of axamination and/or investigation, in my opinion, death	place, and due to the causa(s) and manner as stated. occurred at the time, data and placa, and due to the cause(s)
3	29b. Signature and vitle of certifier 29c. License number D 23371	29d. Date signed (Month, Day, Year) August 14, 1998
State Istrar	30. Name and addrass of person who completed causa of death (Item 23a) (Type, Print) Dr. Qamar Zaman-Johnson Height; s Medical Building- 31. Date filed (Month, Day, Year) AUG 1 8 1998 Augustus Augus	-Cumberland, MD 21502



State of Maryland / Department of Health and Mental Hygiene 98 27345

					Ce	rtificat	e of	Death			Reg. No).		. 105	
		1. Decedent's Neme (First, Middle	le, Last)							2. Date of De			* A Letter	3. Time of	Deeth
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	/Medical	4e Fecility Neme (If not institution		-				4b. City. To	wn. or Lo	AUGUST ocation of Deet		. County		12:4	UPM
	Examiner			iniber)											
		SACRED HEART 5. Social Security Number		7. Age (In yrs.	la ad la lathada	If Under	1 Vear		BERLA 24 Hrs.				GANY	lana (Ctata a	- Carrier
н	Funeral		6. Sex 1 ☐ M 2 2 F		Yrs.	Months	Days	Hours	Min.	(Month, De				lece (Stete o	roreign
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	pug &	10a. Stete 10b. County	,	10c. City	y, Town or Lo	ocation							1	0d. Inside Cit	ty Limits
	ahow d													XXYes	2 □ No
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	r items 23soloses must	212 FULTON STR					2150					U.S.		and to the	
	and and	11. Maritai Status	Armed Fo		,S. 13.	Wes Deced if Yes, spec	dent of h	Hispanic On en, Mexicar	igin? (Spi n, Puerto	ecify Yes or No Rican, etc.))-		e - Americ k, White,		
0	or in	1 Never Married 2 Mar	If Yes. Gi			1□ Yes	XIX No	Specify:				Specify	: B1	LACK	
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/la	should be filed withing Mental Hygiene. marked other than imatic event, the M	JACOB TAYLOR						EDIT	CH HC	DLLINGS'	WORT	H			
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		WILLIAM BECKWA	RD TR	SON	212	FIII TO	M CT	יסבבת	CIMI	EDI AMD	MAD	YLAN	D '	21502	
e,	ges 1 and t of Health if Item 27 or other ti	20e. Method of Disposition	KD JK	20b. P	Plece of Disponentery, cre	osition (Ner	The of	(ALLEL	CORI	BERLAND	20c. L	ocation -	City or To	21502 wn, State	
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н	31 21	23a. Pert1. Enter the disease, o shock, or haert failure. List	complications thet only one cause on	caused the deetl each lipe.	h. Do not en	ter the mod	la of dyi	ng, such es	cardiac	or raspiretory e	errest,			Approximate Interval Bate	ween
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-	executed in and fall-transit			Hypo	teeri	M.		Set) di	5				2 1/2	wks
	oute am	Sequentially list conditions,	D	Doe to (o	r es e conse	quence pf):	/	^	1						
o o	an a riel-i	Sequantially list conditions, if any, leeding to immediate causa. Entar Underlying Cause (Disaase or injury that initiated events		Posts	nate	ol b	201	الايد						2 1/2	wks
68760,	law requires that the death certificate be executed as been signed by the attending physician and a 2 should be detached for use as the burtal-transit npieted by Physician/Medical Examir	that initiated events resulting in death) Last	С	Due to (o	ras e conse	quence of):	10		Λ	2	1		1		
	Aed tiffica	resulting in death) cast		01/1	0-104	15 1	16	20W	d	Doot	red	201	1	2 1/2	wks
Box	that the death cered by the attendire detached for use		d	(- 0001	->09-	- 1							1		
	at the death of the attendetached for us	Part II. Other significant conditi	ons contributing to d	leath but not res	ulting in the u	inderlying c	ausa qi	ven in Pert	1.	23b. Dld	tobacco	o usa co	ntribute to	the cause o	of death?
P.0	by the tached tached	C. C. A 3 C.	1	() (10	Yes 2	21210	3 Pro	bably 4	Unknown
	signed I doe det	20100 CSC	news	00000	ni sea	X .									
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00	The law require sate has been signated bage 2 should	()(ase	162 110	111110	7 7	k				реп	ormed?		co	allable prior t mpletion of c deeth?	ause
3e	has ye 2											*			
100	the kase has page									1 📗	Yes 2	2	11	Yes 2	No
Vital	Physician: The laver this certificate has ral director, page 2 To Be Comp	25. Was case rafarred to madica examiner?		1			0		e of Deet	h (Check only	one)				
of	this of the sal direction of t	1 Yes 2 10			ER/Outpetie		JA		ursing Ho	me 5□Res				у)	
n	ng P frer t nen	27. Mennar of Death 1 Matural 5 ☐ Pandi	28e. Deta (Mor	ot Injury oth, Dey Year)	28b. Time of Injury		28c. Inju Wo			28d. Describe	how inju	iry occur	red		
Division	endi or: A he fu	2 Accident invest	Igation			М	1_	Yes 2	No						
Z	er der rect rect by t	3 ☐ Suicide 6 ☐ Could datam	nined 206. Pleci	e of Injury - At he ling, etc. (Specif	ome, ferm, st	reet, factor	y, office			28f. Location City or To	(Street a wn, Stet	nd Numb (e)	per or Run	I Route Num	ber,
	tal or Attending P rs after death. al Director: After ted in by the funers Certification:	*													
	To the Hospital or Attending Physwithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director After the Completely filled in by the funeral director Addical Certification: To		ng Physician: To the Examiner: On the b	e best of my kno	wiedga, daat	h occurred	at tha ti	ime, dete er	nd plece,	and dua to the	causa(s	s) end ma	anner as s	tated.	(2
	in 24 he Fi piete	one)		nner steted.	and driefor if	0 3 11 3 11 0 11	, wreny	opinion, ude	00001	or the thirt					
	Within To the Common Common N	29b. Signeture end title of certific	er			290	c. Licen	se number			29d. Da	ate signe	d (Month,	Day, Year)	
			111				D 2	3167			ATT	aliom	1.2	1000	
	(20)	30. Neme end eddress of person	who apmoletted care	se of death (item	n 23e) (Tvne	Print)	A.	1 0			_AU(GUST	13	דאאם	
	sel.		NTH.		ZISU		1	(1.1	902	SETON	DRTV	E OII	ארמו מא	AND M	D
	Ctoto	31. Dete filed (Month, Dey, Year,		Registrer's Signe		1.0		- •	302	SEIUN .	DKTA	E UU	IIDEK!	AND M	U.s
	State Registrar	Alic		John da		sold!									
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	Physici /Medi			M	H.	B	UTLE		2. Dete of De Month August	Day 22.,	Yeer	Firm of Feath:
	Examir	ner	4e. Fecility Name (If not Institution, giv. Manor Care Healt						n, or Location of Deeth rgo		of Death e Georg	e's
	Funeral Director		217-30-2300	ex △M 2□F	Age (In yrs. 67	lest birthday) Yrs.	If Under 1 Ye Months De		Min. 8. Dete of Bir Month, Da Aug. 2	, 1930	9. Birthplece (Country) Mary 1	Stete or Foreign
	e Meryland Sa-f show	ctor	Usuel Residence of Decedent 10e. Stete 10b. County Maryland Calver	t	10c. Ci	ty. Town or Lo	cation ce Frede	erick				side City Limits
	3a or 20	al Dire	10e. Street end Number 180 Mason Road				10f. Zip Code 206			10g. Citizen of V USA		
020	within 72 hours effer death with the Menyland ene. than "natural", or Itema 23s or 28s-f show the Medical Evantine must be notified at	by Funeral Director	11. Marital Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceder Armed Force 1 1 Yes 2 If Yes, Give Yeer or Deter	s? No 19!	52-	Was Decedent of Yes, specify C	uben, Mexican, F	n? (Specify Yes or No Puerto Rican, etc.)	Bled	e - American Inc k, White, etc. .: Black	tian,
21215-0020		Completed	15. Decedent's Ec (Specify only highest gra Elementery/Secondery (0-12)		r 5+)	_	dent's Usual Oct kind of work do DO NOT use ref irpenter	cupetion ne during most or ired)	f working		usiness/industry	
Maryland	\$ 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	To Be C	17. Fether's Neme (First, Middle, Last) John		:ler			18. Mother's	Neme (First, Middle,		ohnson	
	Health e tem 27 la other tra		19e. Informant's Neme/Raletionship (1) William A. Butler 20e. Method of Disposition	/Son	20b. I	17125		y View	Lane Uppe	r Marlb		20772
Baltimore,	t. Pege rtment c rtant: If		1 Burlel 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funerel Servica Lican)		oung's	Cemeter	У	8/27/98 Sewell Fun	Hunting	,	D
ä	Depa Impor any ir		Dlady Q.	Lewell		14	51 Dare	s Beach	Rd. Princ	e Frede	me rick, M	D 20678
68760,	Physician people of the people	/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	e. Ter-		or es e consequir es e consequir es e consequir		A Mul Brain	tiple M Rowel	y-elo	mg n	nonths on the
O. Box	the deeth certifi y the ettending sched for use es	Physician/Me	Pert II. Other significant conditions co	ontributing to death	but not res	ulting In the ur	nderiyIng cause	given in Pert I.		tobacco uee con		
<u>α</u>	es thet igned b	by			<u>.</u>							4 Unknown
Records,	e law requ hes been je 2 shoul	Completed								an autopsy rmed?	availeble	on of cause
Vital	ician: The li certificate he rector, pege	Be Co	25. Wes case referred to medical				·	28. Place of	1 □ \ I Deeth (Check only o		1 □ Yes	2□ No
of <	Physician: this certific ral director,	To E	examiner? 1 ☐ Yes 2 ☐ No	Hospitel: 1 ☐ Inpa	tlent 2	ER/Outpetien	t 3 DOA	Whore /	ing Home 5 Resid		er (Specify)	
ivision	or Attending ter death. Irector: After In by the fune	Certification:	27. Menner of Deeth 1 Neturel 5 Pending investigation 3 Sulcide 4 Homicide 6 Could not be detarmined	28e. Plece of I	Day Year)	28b. Time of Injury ome, ferm, stray)	V	Yes 2 No		now Injury occurr Street and Numb vn, State)		le Number,
	To the Hospital of within 24 hours of To the Funeral D completely filled it	edicai C	29a. Certifier (Check only one) Certifying Phy 2 Medical Exam	rsician: To the besiner: On the basis end menner:	of examine	wledga, daath tion end/or inv	occurred et the restigation, in m	tima, data and p y opinion, deeth	place, end due to the occurred et the time,	cause(s) end me date end pleca,	ennar as stated. end due to the c	ause(s)
	To the To the comp	Me	29b. Signeture and title discertifier	8h0	No	201	29c. Lice	onse number	28	29d. Dete signe	d (Month, Day, 1	(ear)
	5		30. Name and address of person who can Rakesh Arora, M		deeth (Iter	n 23a) (Type, I	Print)		Bowie, Mar	yland		U
	Sta	te	31. Date filed (Month, Dey, Yeer)	32. Regis	trar's Signe		4 1					

environi di es ves en ci TATOMA STATE OF THE the transfer of the first of the first and t The second secon The series of th

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Data of Daath 3. Time of Death Month **Physiclan** James Edward Berry Jr. /Medicai Aug 12, 1998 4:20 p.m. 4a. Fecility Nema (If not institution, giva streat and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** 605 Shriver Avenue Allegany

9. Bifthplace (Stata or Foreign
Country) If Under 1 Yaer 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) **Funeral** 1 M 2□ F Days Months Hours Min. Director 214-05-4555 Jul 17, 1916 MD Usual Rasidanca of Dacadent 10e. Stata 10b. County 10c. City, Town or Location r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 10d. Insida City Limits Director 1 Yas 2 No Allegany Cumberland 10e. Street end Number 10f. Zip Coda 10g. Citizan of What Country? Funeral 605 Shriver Avenue 21502 USA 12. Was Decedant Evar In U,S. Armed Forces? 11. Maritel Status Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hyglena. Important: if item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Exeminable. 1 Yes 27 No It Yas, Give Year or Datas: 1 Nevar Married 2 Married 21215-0020 1 ☐ Yas 2 ☑ No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed white 16a. Dacedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 15. Dacadant's Education (Spacify only highast grada complated) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) College (1-4or 5+) 12 Ret. Sales Manager Queen City Dairy Maryland 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be 10 James Edward Berry Sr. Miriam Alice (Llewellyn) 19a. Intormant's Name/Ratationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Route Number, City or Town, State, Zip Coda) Mary H. Berry-wife Baltimore, 605 Shriver Avenue Cumberland MD 21502 20b. Plece of Disposition (Nama of camatary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Steta 1 Buriel 2 Cramation 3 Ramoval from State 4 ☐ Donation 5 ☐ Othar (Specify) St, Mary's Cemetery 08/15 Cumberland MD 21. Signetus of Funeral Se 22. Nama and Addrass of Facility Scarpelli Funeral Home, P.A. Cumberland MD 21502

Alions that caused it a death. Do not entar tha mode of dying, such as cardiac or respiretory arrast, causa on each lin Approximate Intervel Batwean Onsat and Deeth Physiclan /Medical Immadiate Causa (Final Myocardial 15 minules disaasa or condition rasulting in daath) Examiner The law requires that the death certificate be executed attending physician and I for use as the burial-transit Sequantially list conditions, if any, laading to immadiata ceusa. Entar Undarlying Cause (Disaasa or Injury that initieted avants resulting in daath) Last Due to (or as a consequence of). Box 68760 Physician/Medical Due to (or as a consequence of): 14/2/1998 signed by the at Part II. Other significant conditions contributing to death but not rasulting in the undarlying causa given in Pert t. Division of Vital Records, P.O. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown by 24b. Wera autopsy findings evailable prior to completion of cause of death? Completed 24a. Was an autopsy performed' 1 🗆 Yes certificate 2 No 1 Yas 2 No or Attending Physician: Be 26. Place of Death (Check only ona) Hospitat: 1 ☐ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA Othar: 4□ Nursing Homa 5 Residenca 6 □ Othar (Specify) Certification: To this 28a. Deta of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Tima of 28c. Injury at Work? 28d. Describe how Injury occurred After 1 Naturel 2 Accidant 5 Pending invastigation death. 1 Yes 2 No 24 hours after deat Funeral Director: 6 Could not be detarmined 3 Suicida 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) Place of Injury - At homa, tarm, straat, factory, office building, atc. (Spacify) 4 Homicida Hospital 29a. Cartifian Certifying Phyaician: To tha best of my knowledga, daath occurred at tha tima, data and placa, end dua to tha causa(s) end menner es statad.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and placa, end due to the cause(s) end mannar stated. edical To the Hoss within 24 ho To the Fune completely fi (Check only one) 29b. Signature end titla of certifier 29c. Licansa number 29d. Data signed (Month, Day, Year)

State

Dr. Sunil K. Gupta 625 Kent Avenue Cumberland MD 21502
31. Data filed (Month, Day, Year) 32. Registrar's Signature

AUG 1 1998

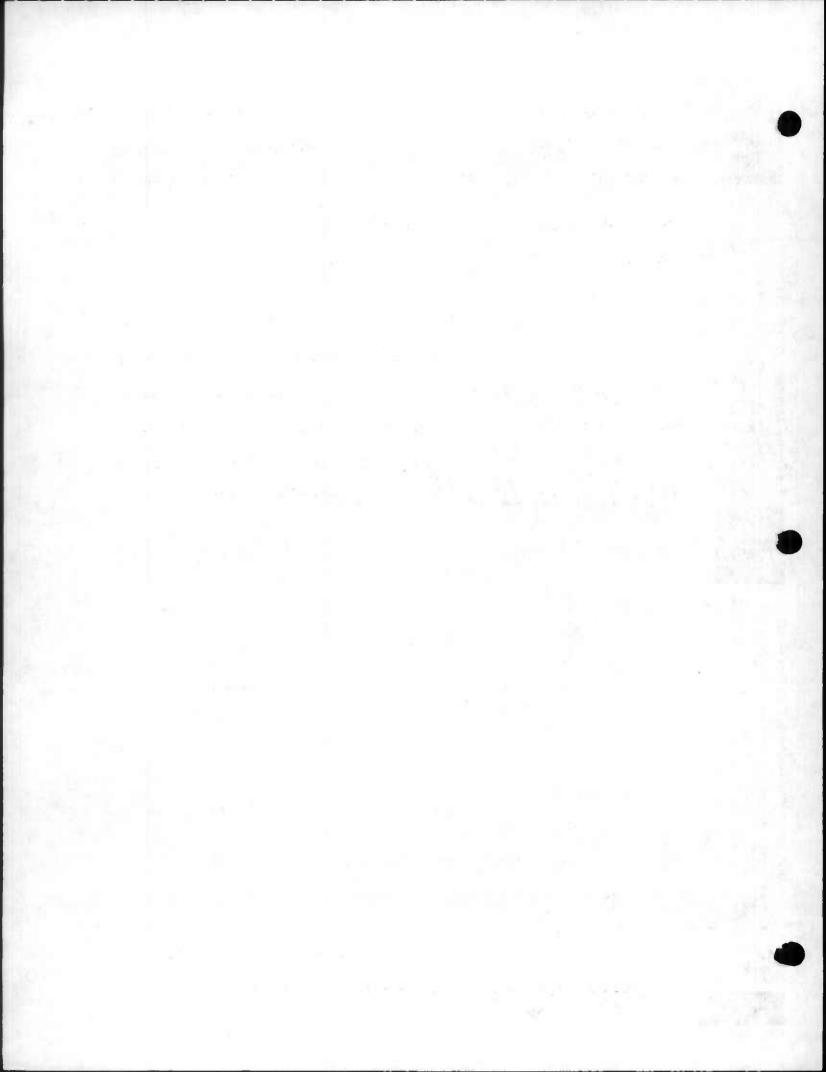
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30. Nama and eddress of person who completed causa of deeth (Itam 23a) (Type, Print)

13.1998

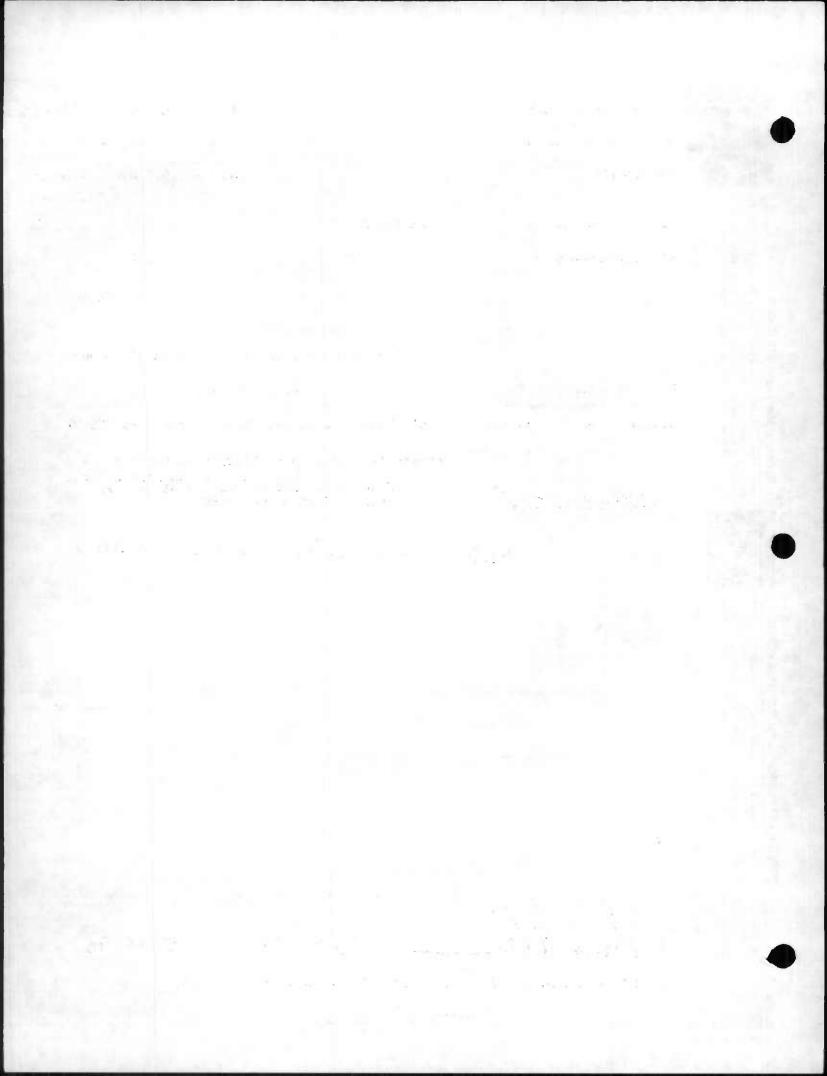
Registrar



State of Maryland / Department of Health and Mental Hygiene

					Cer	tificat	e of I	Death	1000000	Reg. No.	610	
sician	1. Decedent's Name (F								2. Data of D Month	Day	Yaar	Time of Death
ledical	Elizabet								Augus			8:30 PM
miner	4a Facility Name (If no						4	b. City, Town, o	or Location of Dea	th 4c. Count	of Death	
	411 Lexing	gton Dri	ve						Spring		tgomery	
eral	5. Social Security Numb		7. Ag	e (In yrs. la	st birthday)	If Under Months	1 Year Days	If Under 24 H Hours M		irth Jay, Year)	9. Birthplace (State or Foreign
tor	577-28-477	7.5	281	81	Yrs.				June	1, 1917	North Ca	arolina
	Usuet Residence of Dec 10a. State 10	b. County		10c City	Town or Lo	cation					10d In	side City Limits
Irector	Toa. State	o. County		Too. Oity,	TOWN OF LO	Callon						Yas 25 No
cto		lontgome	ry		Silve							
Funeral Director	10e. Street and Number	r				10f. Zip	Code			10g. Citizen of	What Country?	
<u>8</u>	411 Lexing	gton Dri	ve			20	901			US	A	
ner	11. Marital Status		12. Was Decedant Armed Forcas?	Ever in U,S	13. \	Vas Dece	dant of H	Ispanic Origin?	(Specify Yes or Nerto Rican, etc.)	14. Ra	ce - American Indick, White, etc.	dian,
by Fu	1 ☐ Never Marriad 3 ☐ Widowed 4 ☐		1 Yas 2 XM If Yes, Give Year or Dates:	10				Specify:		Speci		2
Pa	15.	Decedent's Edu	ucation		16a. Deced	lent's Usu	al Occup	ation		16b. Kind of E	lusiness/Industry	
Completed	(Specify o	only highest grad	le completed)		(Giva life. l	kind of wo	rk done i se retired	during most of v	vorking			
E	Elementary/Seconda	19 (0-12)	Coltege (1-4or 5	17)	Finan	cial	Admi	nistrat	or	Beauvo	ir Schoo	0.1
	17. Father's Name (Firs	t, Middle, Last)							ame (First, Middle			
o Be	Malcolm An							Minni	Le Godle	17		
F	19a. Informant'a Name.		vne Print)		19h Mailie	a Address	S (Street		Rural Route Num		State Zin Code	a)
	George B. 20a. Method of Disposit		JI. (SOII)	20h Di					Silver		MD 2090 - City or Town, S	
			Removal from State		metery, cren							1210
	4 Donation 5			Met					8/28/98		-	
.000	21. Signature of Funera	al Service Licens	7/		22 H	. Name a	Inc.	ss of FacilityF1	ancis J Iniversi	Collin	s Funera West	1
phoe.	Illan	10.	201					ring, N				
Aedical Examiner	disease or condition resulting in death) Sequentially llst conditi if eny, leading to immacause. Enter Underlyic Cause (Disease or injuthat initiated events resulting in death) Last		b	Due to (or	as a consequence as a c	uence of)			Later			
Physician/M			d									
SIC	Part II. Other significan	nt conditions co	ntributing to death b	ut not resul	lting in tha u	ndarlying	cause giv	en in Part I.	23b. DI	d tobacco usa c	ontribute to the	cause of death?
									1[Yes 2□No	3 Probably	4⊠ Unknown
leted by Physic									0.60 181	is an autopsy	24b Were at	utopsy findings
tec										formed?	availabt	e prior to tion of causa
9											of death	?
Completed									10	Yes 2 No	1 ☐ Yes	2□ No
Be	25. Was casa refarrad	to medical						26. Place of I	Death (Check only	one)		
0	examiner? 1 ☐ Yes 2 ☐ No		Hospital: 1 ☐ Inpatie	nt 2 E	R/Outpatier	t 3 D	OA Oth	er: 4 Nursing	Home 5 Re	sidence 6 🗆 O	her (Specify)	
	27. Manner of Death		28a. Date of Inju (Month, Da		28b. Time of	_	28c. Injur Wor			e how injury occu		
cation	1 ☑ Natural 5	Pending Investigation	(Month, Da	y rear)	Injury	М		Yes 2 □ No				
Certification:		Could not be determined	28e. Place of Inj building, et	ury - At hor c. (Specify)	ne, farm, str	eet, factor	y, office			(Street and Num own, State)	ber or Rural Rou	ita Number,
completely tilled in by Medical Certifi			atcian: To the best of									
Med Med	non Cinner of an Inc.	of motion /	ang majiner sti	1100.		00	o Licera	a number		29d Data size	ed (Month, Day,	Vest)
-	29b. Signature and title	of certifier	1/1/			1 4		e number		-1	6 98	-
)	- M	nonly	Un				V	w 694		012	61-19	
	30. Name and address											
	Brian H.	Avin, M.	D., 2730	Unive	ersity	Blv	d., 1	Vheaton	, MD 20	902		
		Day, Year)	32. Registr									

DHMH 16 Ray 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Physician James McCrory Beach August 27, 1998 6:39 AM /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Neme (If not institution, give street and number) Examiner 7665 MacArthur Blvd. Cabin John Montgomery If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Yeer) 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplece (Stete or Foreign Country) **Funeral** Months 1⊠M 2□ F Yrs. 578-54-5391 56 Director Sept. 12, 1941 Washington, DC Usuel Residence of Decedent with the Maryland 10e Stete 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 10b. County 1X Yes 2 No Directo Maryland | Montgomery Cabin John 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code I is marked other than "natural", or items 23s or items(covert, the Medical Examiner must be 7665 MacArthur Blvd. 20818 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Bleck, White, etc. 1 XYes 2 No If Yes, Give Not Yeer or Dates: AVailable 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☒ No Specify: Specify: p 3 ☐ Widowed 4 ☐ Divorced White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decadent's Education (Specify only highest grede completed) Washington Gas Elementary/Secondary (0-12) College (1-4or 5+) Design Specialist Light Company 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) Be Carl Farthering Beach Elizabeth Wightman 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) 7665 MacArthur Blvd., Cabin John, Maryland 20818 Martha A. Beach/Wife 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) Aug. 30, 1998 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Parklawn Memorial Park Rockville, Maryland 22, Name, and Address of Fecility
Robert A Pumphrey Funeral Home/Bethesda-Chevy
Robert A Pumphrey Funeral Home/Bethesda-Chevy
Robert A Rob Approximeta Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in death) Acute Myocardial Infarction Immediate Examiner Due to (or es e consequence of) Examiner Coronary Artery Disease Unknown requires that the death certificate be executed attending physician and for use as the bunal-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or es e consequença of). Physician/Medical that initiated events resulting in deeth) Lest Due to (or es e consequence of): ed by tha a detached f 23b. Did tobacco use contributa to the causa of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2⊠ No 3 Probably 4 Unknown Hypertensive Cardiovascular Disease p 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed 24a. Was en eutopsy Obesity certificate has blirector, page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No Attending Physician: 25. Wes case referred to medical examiner? Be 26. Plece of Death (Check only one) Other: 4☐ Nursing Home 51 Residence 6 ☐ Other (Specify) 1 No Yes 2 No 10 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA this funaral 28e. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: After 5 Pending investigation 1 Netural 1 ☐ Yes 2 ☐ No r death. 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 3 ☐ Suicide 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide after 0 To the Hospital within 24 hours a To the Funeral C complately filled 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the cause(s) and manner es steted.

2 Medical Examinar: On the basis of exeminetion end/or investigation, in my opinion, death occurred et the time, dete end placa, end due to the cause(s) end menner stated. edical 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of certifier 10+1 DC6104 August 27, 1998 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) Thomas C. Havell, II, M.D. 4201 Cathedral Avenue, NW Washington, D.C. 31. Dete filed (Month, Day, Year) 32. Registrer's Signature

DHMH 16 Rav 6/95

Registrar

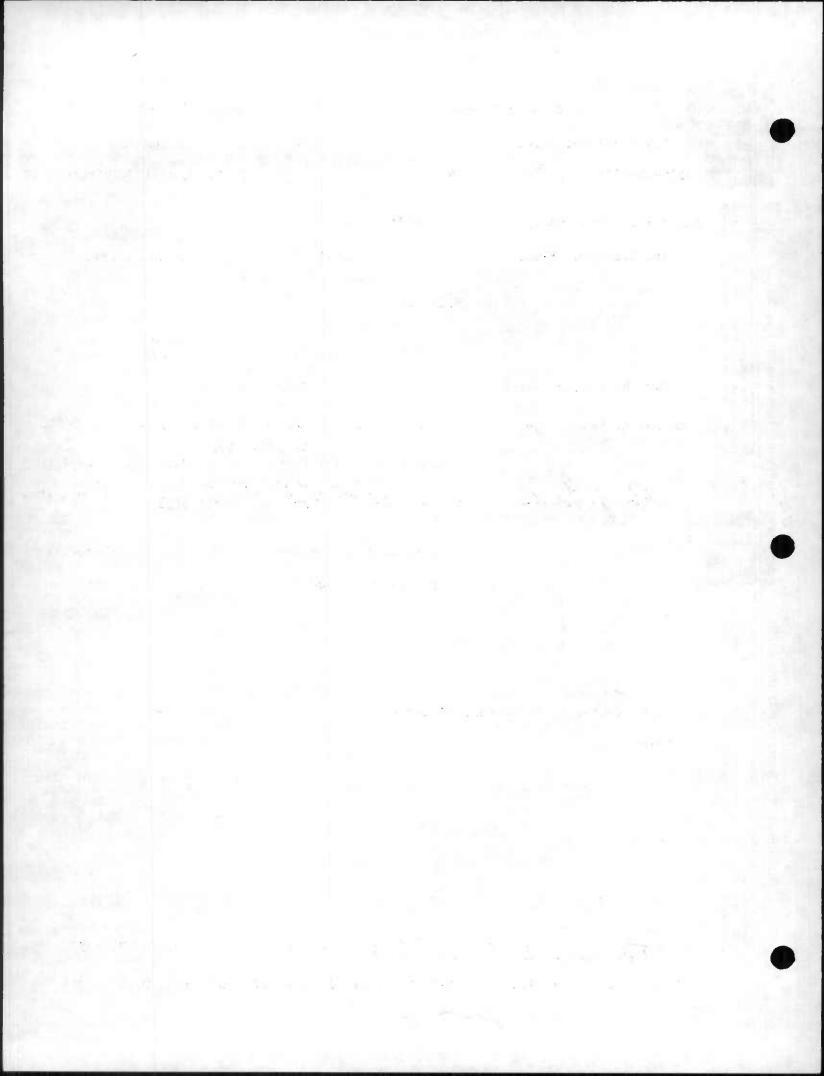
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Box 68760.

P.O.

Division of Vital Records,

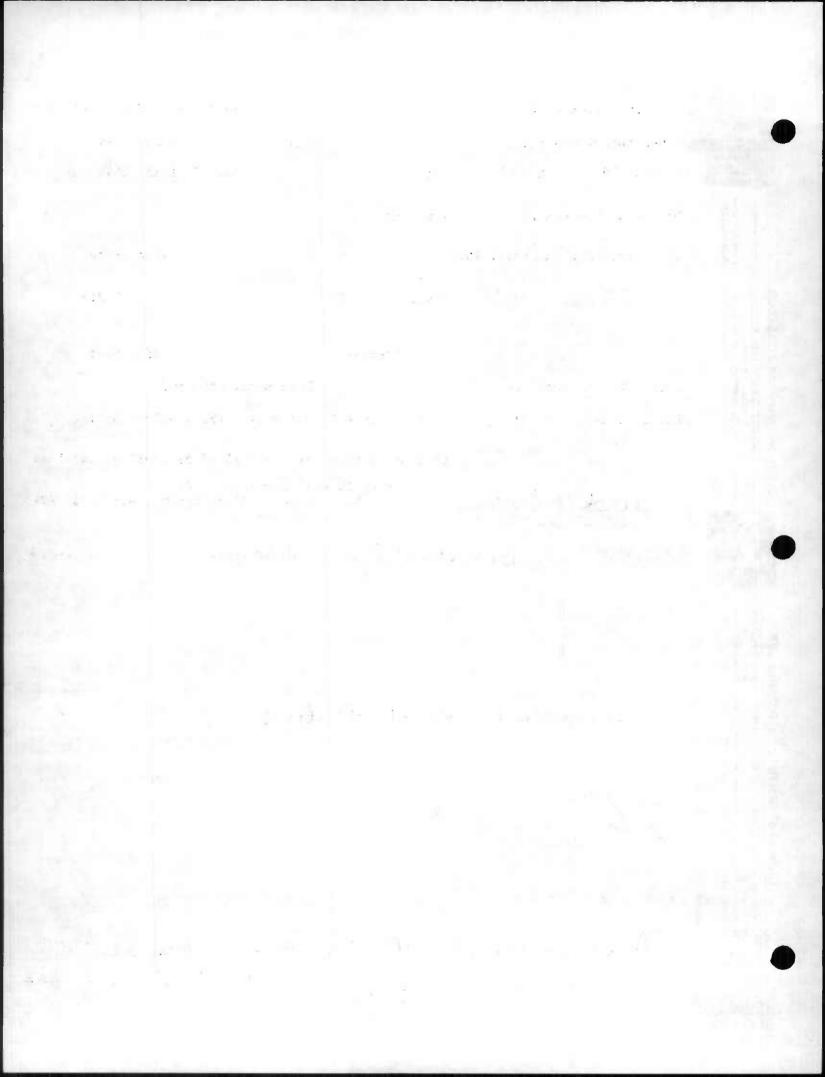


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Time of Death 2. Data of Death 1. Decedent's Name (First, Middla, Last) **Physician** 11:29 AM Morris Victor Boley August 22, 1998 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Neme (If not institution, give street end number) Examiner Montgomery General Hospital If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Year) | Jan. 17, 1915 Olney Montgomery 7. Age (In yrs. lest birthday) 5. Sociel Security Number 6 Sax Birthpleca (State or Foreign Country) **Funeral** 1₩ M 2□ F Yrs. 83 Oklahoma 554-54-6793 Director Usual Residence of Decedent the Maryland 10e State 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland Montgomery Silver Spring 1 Yes 2 No Directo 10e. Street end Number 10f. Zip Code 10g, Citizen of What Country? Pages 1 and 2 should be filed within 72 hours efter death with 1 and of Health and Mentel Hygiene.
Int: if item 27 is marked other than "netural", or items 23a or 1 inty or other traumatic event, the Medical Estating man by or other traumatic or and the stating or other traumatic or and the stating or other traumatic or other traumati 20906 15101 Interlachen Drive, #516 United States Funeral 12. Wes Decedent Ever in U.S.
Armed Forcas? WWII
1 M Yes 2 Wo
If Yes, Give & Korean
Year or Dates: 14. Race - American Indien, Was Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) Black, Whita, etc. 1 Never Married 2X Married Baltimore, Maryland 21215-0020 1 Yes 2 No Spacity: Specify: White à 3 ☐ Widowad 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elamantary/Secondary (0-12) U.S. Mint Chemist 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fathar's Name (First, Middla, Last) Lola Ethel Drummond George Washington Boley 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Relationship (Type, Pnint) 15101 Interlachen Drive, #516, Silver Spring Zoe M. Boley (wife) 20b. Place of Disposition (Name of cametery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stata permit. Page Depertment of Important: If any injury or Chesapeake Crematory 8-24-98 Beltsville, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility
Rapp Funeral Services, P.A. 21. Signature of Funeral Service Licensee and 933 Gist Avenue, Silver Spring, Maryland 20910 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardlac or respiretory arrest, shock, or heart failure. List only one ceuse on each line. Approximete Intervel Between Onsat and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Brondiolilis Oblitera ul 2 week Examiner Examiner the death certificate be executed physician end the burial-transit Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Lest Due to (or es e consequença of): Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or es e consequence of): 98 esn signed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the causa of death? 3 Probably 4 Unknown 1 TYes 2 No þ 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? leted 24e. Wes en eutopsy performed? certificate hes b irector, page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? Be 26. Plece of Deeth (Check only one) 1 Yes 2 No Other: 4 ☐ Nursing Homa 5 ☐ Residenca 6 ☐ Other (Specify) 2 1 ☐ Inpatient 2 DER/Outpetient 3 ☐ DOA this 28d. Describe how injury occurred 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. tnjury et Work? Certification: I or Attending P efter death. Director: After I After 1 Naturel 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined To the Hospital or Attention 24 hours efter des To the Funeral Director completely filled in by the 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 4 Homicide Certifying Phyeicien: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

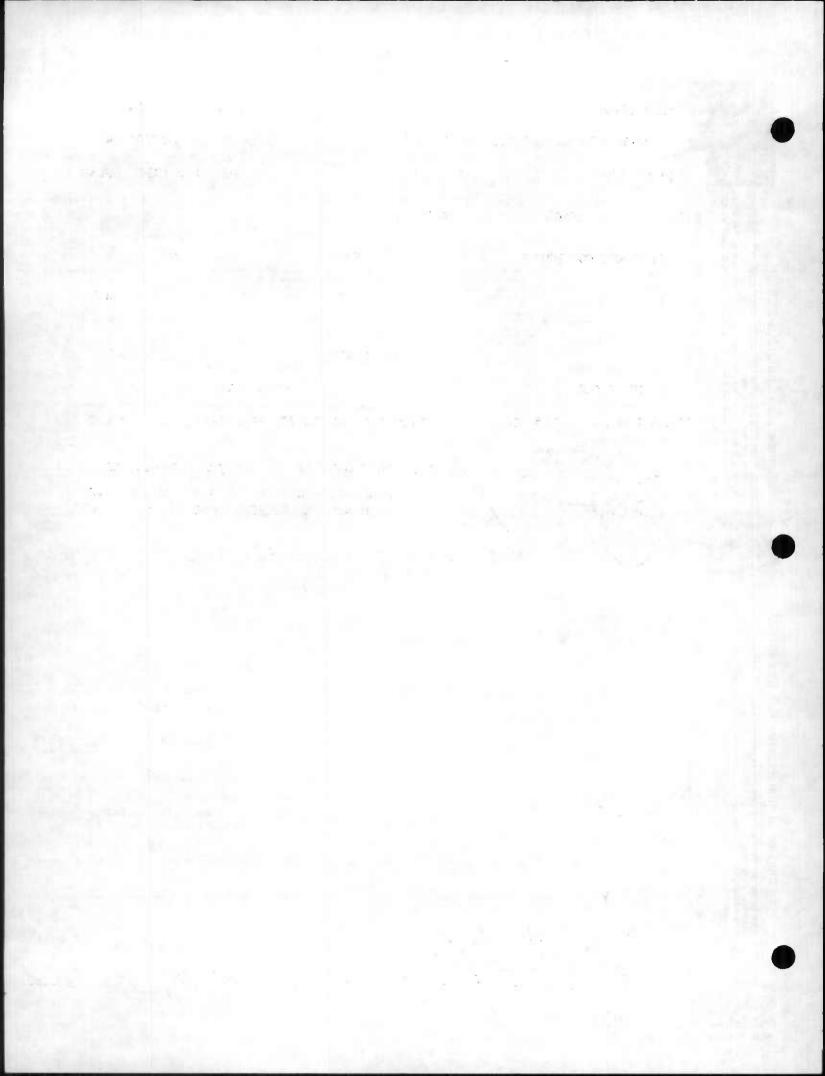
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) 29c. Licanse number 29d. Date signed (Month, Dev. Year) 29b. Signeture and titla of certifier 20 D38262 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

Dr Mendhiralta 18111 Pr Philip Dr Srute 212 0 Iney 20832 MD 31. Deta filed (Month, Dey, Year) 32. Degistrar's Signeture State 2 4 1998 Registrar



State of Maryland / Department of Health and Mental Hygiene

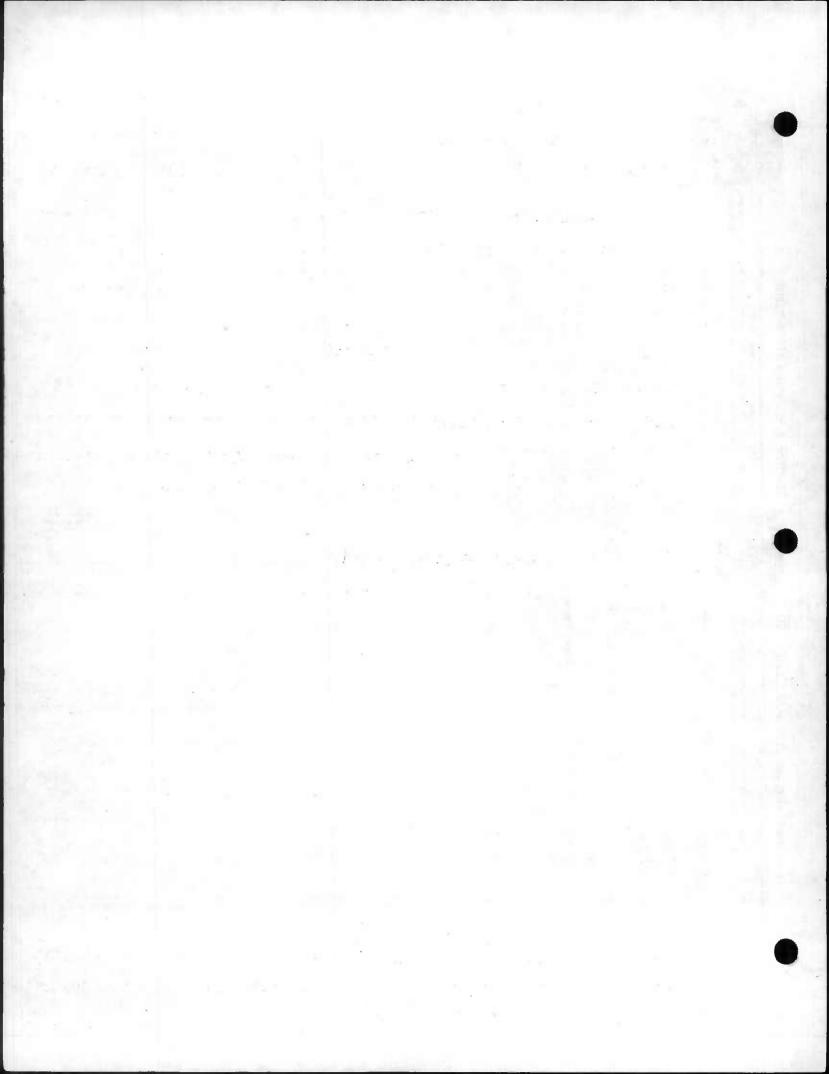
Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Dey Yee **Physician** 11:30 PM AUG 25 1998 ROSE BROWNER /Medical 4a Facility Nama (If not institution, giva straat and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner HEBREW HOME OF GREATER WASHINGTON ROCKVILLE MONTGOMERY If Under 1 Yeer 8. Data of Birth (Month, Day, Year) 9. Birthplece (Steta or Foraign 7. Age (In yrs. last birthday) **Funeral** Months Deys Hours 1□M 2XF SEPT 17, 1907 POLAND Director 061 01 3740 Usual Residence of Decedent death with the Meryland 10e Stete 10h Count 10c. City, Town or Location 10d. Inside City Limits r 28a-f show VA **FAIRFAX** ANNANDALE 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? "naturel", or items 23s or 5120 RED FOX DRIVE 22003 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Datas: 14. Rece - American Indian. 11. Meritel Stetus Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. permit. Peges 1 end 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iten any injury or other treumstic event, it a Mexical Evant 1 ☐ Never Merried 2 ☐ Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: WHITE p 3 Widowed 4 □ Divorced Completed 16e. Decedant's Usuel Occupetion (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 12 18 Mother's Name (First Middle Meidan Sumeme) 17. Fether's Name (First, Middle, Last) Be HARRY NEYER FANNIE YERLICH 19b. Meiling Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 5120 RED FOX DRIVE, ANNANDALE, VA. DIANA LONDON (DAUGHTER) Plece of Disposition (Name of cametery, cremetory or other pleca) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Buriaf 2 ☐ Cremation 3 ☐ Removef from Stata 4 ☐ Donation 5 ☐ Other (Specify) KING SOLOMON GARDENS 8/27/98 CLIFTON, NJ rvice tinens DANZANSKY-GOLDBERG MEMORIAL CHAPEL, INC used the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, HLLE, MD 20852 Intervel Between Onset end Death **Physician** Immediate Ceuse (Final disease o condition resulting in Sec. 1) OF ALZHEIMER'S TYPE /Medical O YEARS EN Examiner Due to (or es e consequenca of): Examiner physician end the burief-transit that the death certificete be executed Sequentially list conditions, if eny, feeding to immediate causa. Entar Underlying Ceusa (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): P.O. Box 68760. Physician/Medical Due to (or es e consequenca of) ettending pl signed by the e 23b. Did tobacco usa contributa to the cause of death? Pert If. Other algorificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Records. P 24b. Wara autopsy findings evailable prior to completion of cause of deeth? Completed 24a. Was an autopsy performed? is certificate hes by director, page 2 s The law 1 □ Yes 2 □ No 1 Yes al No Division of Vital Attending Physician: 25. Wes case referred to medical Be 26. Place of Beath (Check only ona) exeminer? Other: Nursing Home 5 Residence 6 Othar (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this funeral 28e. Dete of Injury (Month, Dey Year) 27. Manper of Death 28b. Tima of 28c. Injury et Work? 28d. Describe how injury occurred Certification: After 1 Naturaf 2 ☐ Accidant 5 Pending 1 Yes 2 🗆 No death. Investigation or Attendent efter deat Director: 6 Could not be n 24 hours efter des re Funeral Director pletely filled in by the 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 28e. Pfaca of Injury - At home, farm, street, factory, office building, atc. (Specify) Hospital To the Hospi within 24 hou To the Fune 29a. Certifian 10 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha ceuse(s) and menner as stated. Medical 2 Medical Examiner: On the besis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, data and piece, end due to the causa(s) end mennar stetad. 29c. Licanse number 29d. Date signed (Month. Day, Year) 29b. Signature and title of certain Mysician 44GUST 26, 1998 1808 wy 30. Neme and addrass of person who completed cause of gleeth (Itam 23a) (Type, Print) ATEL Mont-6/2 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State Registrar 2 8 1998



State of Maryland / Department of Health and Mental Hygiene

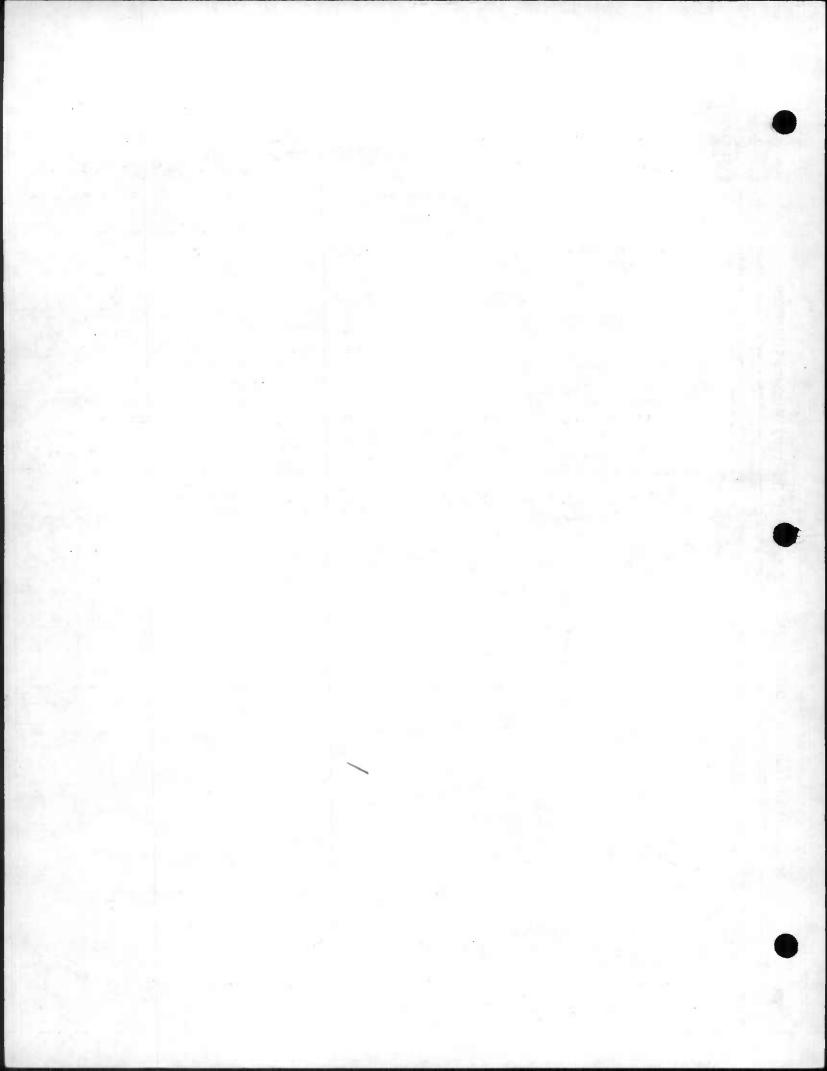
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death AUGUST **Physician** 21, 1998 11:55 P EMMA C. /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Deeth Examiner MONTGOMERY OLNEY MONTGOMERY GENERAL HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Yaar) Apr. 7, 1913 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign **Funeral** Deys Months Hours 1□M 2XF Maryland Yrs. 215-18-9817 85 Director **Uauel Rasidence of Decedent** 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itama 23a or 28a-f ahow the Madical Examinar must be notified at 1 ☐ Yes 2 No Director Silver Spring MD Montgomery 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? 20906 3612 Bel Pre Road, Apt. U.S.A. Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Status Pages 1 and 2 should be filed within 72 hours efter inent of Health and Mertel Hyglene.
ant: if item 27 is marked other than "natural; or health yor other traumatic event, its land." 1 Yes 2 No
If Yes, Give
Yeer or Detes: 1 Never Merried 2 Married Specify: Black Baltimore, Maryland 21215-0020 1 Yea 2 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home 8th Domestic 17 Fether's Neme (First Middle Last) 18. Mothar's Nema (First, Middle, Maiden Sumeme) Be Norman E. Budd, Sr. Sadie Matthews 19a. Informent's Neme/Reletionship (Type, Print) Grand-19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Steta, Zip Code) 825 Geronimo Drive, Frederick, MD 21701 Marilyn Foreman (Daughter) 20b. Plece of Disposition (Neme of cemetary, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removel from State permit. Page Depertment of Important: If eny injury or once. Metropolitan Fun. Serv 8/27/98 Alexandria, 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Fecility
SNOWDEN FUNERAL HOME, P.A. 21. Significant of Funeral Service Lipersee 20850 ROCKVILLE, MD Part I. Enter the disease, or confplications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hearly ailure. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** Immediate Cause (Final disease or condition rasulting in daath) /Medical · Metastatic DAYS ON Examiner Due to (or as a consequence of): Examiner 10 minutes AKRES physicien end s the burial-transit ial The lew requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Diaaase or Injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of) 080 P.O. 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown Records, à 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed page 2 a 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No this certificate Division of Vital 25. Was case rafarred to medical examiner? Be 26. Placa of Death (Check only ona) 1 Yaa 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 28b. Time of Injury 27. Mennar of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury et Work? To the Hospital or Attending Pi within 24 hours effer death. To the Funerel Director: After ti completely filled in by the funera Certification: 1 DeNeturel 5 Panding 1 TYes 2 No invastigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicida 1 Certifying Physician: To the best of my knowledge, deeth occurred et tha tima, data end plece, end dua to the ceuse(s) end manner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at tha time, data end plece, end due to the ceuse(s) end menner steted. edical 29e. Certifie (Check only one) 29b. Signeture end title of certified 29c. License number 29d. Date signed (Month, Day, Year) August 22, 1998 n. Neme end address of person who completed cause of death (from 23a) (Type, Print) Branboow 3416 Orandwood Ct, Suite 205, Olney, MD 20832 7. Arthur 31. Dete filed (Month, Day, Year) 32. Registrar's Signeture State AUG 2 6 1998 Registrar



State of Maryland / Department of Health and Mental Hygiene

		Otato of Mary		ertificate of		R	eg. No.	27353
Physician	Decedent's Nama (First, Middla, Last					2. Data of Dea Month	Day	3. Tima of Dea
/Medical	Pauline C					August		998 6:10A.1
Examiner						Location of Death	4c. County	of Death
16.4	11901 Rocking	Horse Road			Rockvil		Montg	
Funeral Director	5. Social Security Number 6. S 577-05-8664 1 Usual Rasidance of Decedant	ex	rs. last birthda Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs Hours Min			9. Birthplace (State or For Country) Pennsylvania
and and	10a. Stata 10b. County	10c.	City, Town or	Location				10d. Inside City Lir
the Marylan 28s-f show notined	Florida Osceola	I	Kissimm	ee				1 □ Yes 2 X
5 0 8	10e. Street and Number 3650 North Gate 1	rive		10f. Zip Code 34746			og.Citizen of W nited S	
- 5 2 E	11. Marital Status 1 □ Nevar Married 2 □ Married	12. Was Decedent Evar in Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Giva Yaar or Datas:	n U,S. 13	B. Was Decedent of I If Yes, specify Cub			14. Race Black	- American Indian, k, Whita, atc. White
72 hours natural,	15. Decedent's Ed		16a. Dec	cedent's Usual Occur	pation		16b. Kind of Bu	siness/Industry
ind 21215-0020 be filed within 72 hours af tel hygiene. d other than "natural", or event, the Medical Exam Re Completed by R	(Specify only highast gra		(Gi	ve kind of work done . DO NOT use retire	d)		Montgom	ery County Department
other went, the	17. Fathar's Nama (First, Middla, Last)			Secr	etary	ma (First, Middle,		
Maryland d 2 should be flie th end Mentel be traumatic event traumatic event	A 11						Marueri Surrami	a <i>)</i>
ylan ouid be ouid be wented or matic eve						Shifer		
Aar 2 sho end le m	19a. fnformant's Name/Ralationship (iling Address (Street				
and and 127	Loretta B. Harris	s/Daughter	1755	Conifer	Avenue,	Kissimmee	-	
Baltimore, Maryland semit. Pages 1 and 2 should be files begarment of Heelith and Mentel Hy mportant: if item 27 is marked othe iny injury or other traumatic event, and.	20a. Mathod of Disposition 1 X Burial 2 Cremation 3 C 4 Donation 5 Other (Specify	Removal from State	ort Lin	position (Nama of rematory or other planto)	ce) August	22, 1998 _E		city or Town, Stata
Baltimore, M permit. Pages 1 and 2 Department of Heelth important: if Nam 271 any injury or other tre page.	21. Signatura of Funaral Sarvice Licen	V // ,		Rockville	Inc.	300 West	Montgom	ey Funeral H ery Avenue
	23a. Part1. Entar tha disaasa, or com shock, or haart failura. List only			Rockville				Approximete friterval Between
Physician /Medical Examiner	Immediata Causa (Final disaesa or condition rasulting In death)	0.	static o (or as a cons	Cancer, Presequence of):	rimary,	Unknown		Years
58760, icate be executed physicien end s the burial-transit	Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Causa (Disease or Injury that Injitaled avents.)	b. — Dua to	o (or as a cons	equence of):				
= 00 =	rasulting in death) Last	Dua to	o (or as a cons	equence of):			- 13	
death cer death cer e ettendir ad for use	Part II. Other significant conditions of	entributing to death but get	moulting in the	undarbing cause of	ven in Bart I	23b Did to	hacco use con	tribute to the cause of de
P.O. d by th	Parti. Other significant conditions of	SHIRIDDING TO GOALLS DOC FLOT	rasulting in the	undenying cause gi	voil wi Felt I.			3 □ Probably 4 K Unio
Cords, v requires been sign should be						24a. Was a perfor	n autopsy med?	24b. Were eutopsy findin available prior to completion of cause of death?
						1 D Y	as 2 No	1 ☐ Yes 2 ☐ No
/ital					26 Place of De	eth (Check only or	ne)	
of Vital Representations of the leading of the leading the leading of the leading	examinar? 1 ☐ Yas 2 ☒ No	Hospital: 1 Inpatient	□ FR/Outnet	ient 3 DOA Ot				or (Specify) Son's
On of offing Phy his After this funeral of tuneral control.		28a. Data of Injury (Month, Day Year		of 28c. Inju	ny at rk? Yes 2 No	28d. Describe h		
Division o To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral Medical Certification:	3 Suicida 6 Could not be determined		t homa, farm,	street, factory, office		28f. Location (S City or Tow		er or Rural Routa Number,
To the Hospital or within 24 hours after to the Funeral Dir completely filled in Medical Cert	29a. Cartifliar 1 Certifying Phy (Check only one) 2 Medical Exert	/sician: To the best of my liner: On the basis of axam and mannar stated.						
within 2 To the comple	29b. Signatura and titla of certifiar			29c. Licen	se number	2	9d. Date signed	(Month, Day, Year)
20	1		and	D23	3540	W I	August :	19, 1998
	30. Nama and address of person who of Hugh Hill, M.D.				310. Roc1	kville M	arvland	20850
State	31. Data filed (Month, Day, Year)	32. Registrar's Si		book	20, 200		/	20030
Registrar	AUG 2 6 1998	No Park	N. 1	your				



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 20:43 20 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Neme (If not Institution, give street end number) Westminster Carroll Carroll County General Hospital 9. Birthplece (State or Foreign Country) New York If Under 1 Year 8. Date of Birth (Month, Dey, Yeer) Aug 19, 1914 7. Age (In yrs. lest birthdey) 5. Sociel Security Number Months Deys Hours 1 M 20XF 84 Yrs. 057-07-7181 Usual Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Sykesville Carroll 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21784 U.S.A. 6407 Glasgow Circle 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Rece - American Indien. Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Detes: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/industry College (1-4or 5+) Elementary/Secondary (0-12) Domestic 12 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) (Unknown) Myron Finch Emily 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informant's Neme/Reletionship (Type, Print) 6407 Glasgow Circle Sykesville, MD 21784 Mr. Harry E. Blair (Husband) 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Buriel 2 Cremation 3 Removal from State 4 Donetion 5 Other (Specify) 8/23/98 Springfield Cemetery Sykesville, MD 22. Name end Address of Fecility 21. Signeture of Funeral Service Licenti HAIGHT FUNERAL HOME & CHAPEL (Box 195) O. Dugly Sykesville, MD 21784 (410)-795-1400 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List *on*ly one cause on each line. Approximete Intervel Between Onset and Deeth Immediete Ceuse (Final disease or condition resulting in death) · Biventricular heart Due to (or es a consequence of): teur tibrillatio Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in deeth) Lest Due to (or es e consequence of) Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24e. Wes en eutopsy performed? 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 200 NO 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work?

ettending physician end of for use as the bunal-transit certificate be executed chartine the signed by to peen has certificate this funeral Director: After or Attending r death. 6 within 24 hours

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Directo

Funeral

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Completed

ir than "natural", or items 23a or 28a-f showing Medical Examiner must be notified at

permit. Pages 1 end 2 should be filed within 72 hours efter Department of Health and Mental Hygiena. Important: if item 27 is marked other than "natural; or ite any injury or other traumatic avent, in Medical Examp.

Physician

/Medical

Examiner

Physician/Medical Examiner

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Completed

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Certification:

edical

with the Maryland

death

25. Wes cese referred to medicel examiner? 1 Yes 2 No 27. Menner of Deeth 1 Matural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and plece, end due to the ceuse(s) and menner as stated

29a. Certifie (Check only

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier

m.D D0052×79 august, 20, 30. Name and address of parson who completed cause of deeth (Item 23a) (Type, Print) LISA KTM, M.D. at Carroll County Hospital at 200 memorial Avenue, west minster, MD 21151 General

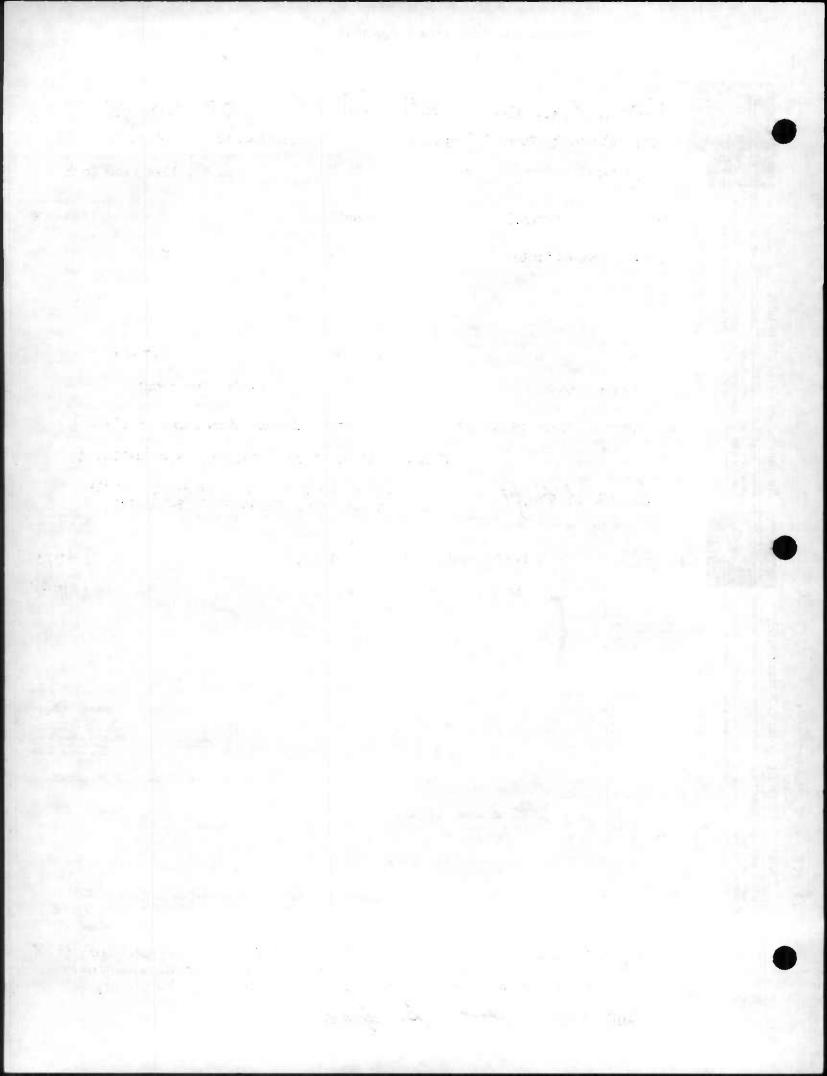
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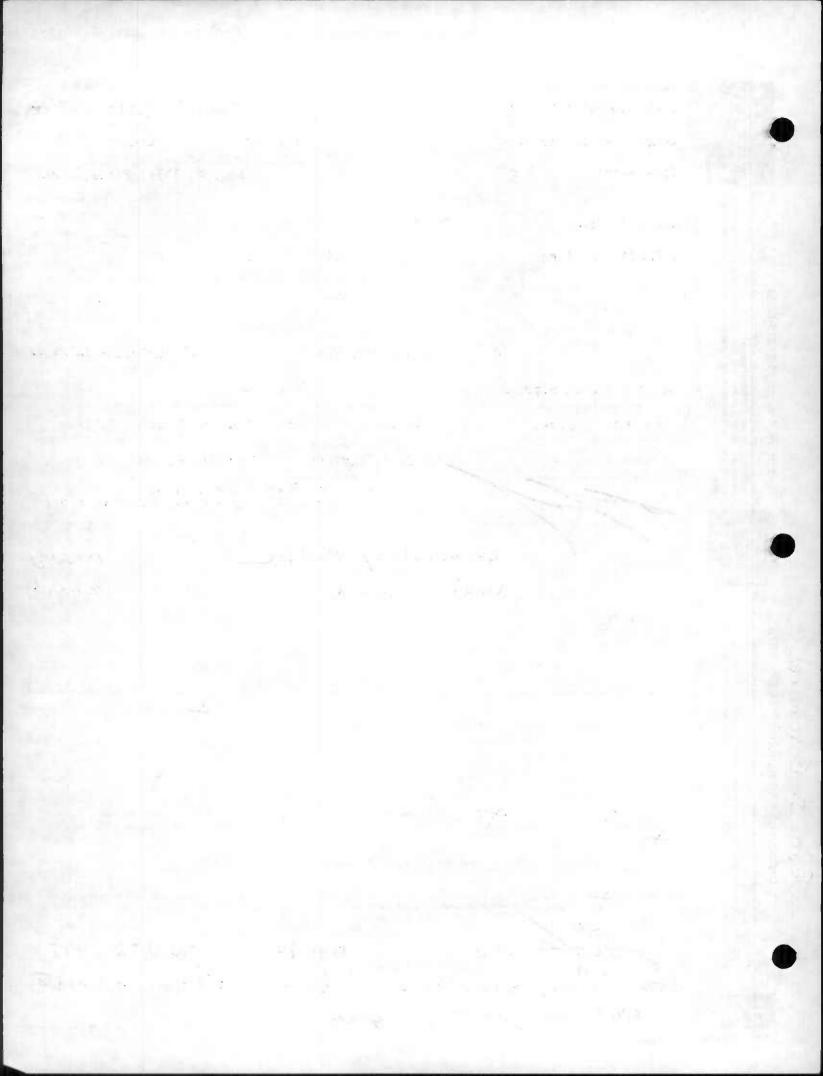
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31. Dete filed (Month, Day, Year) AUG 2 6 1998

32. Registrer's Signeture

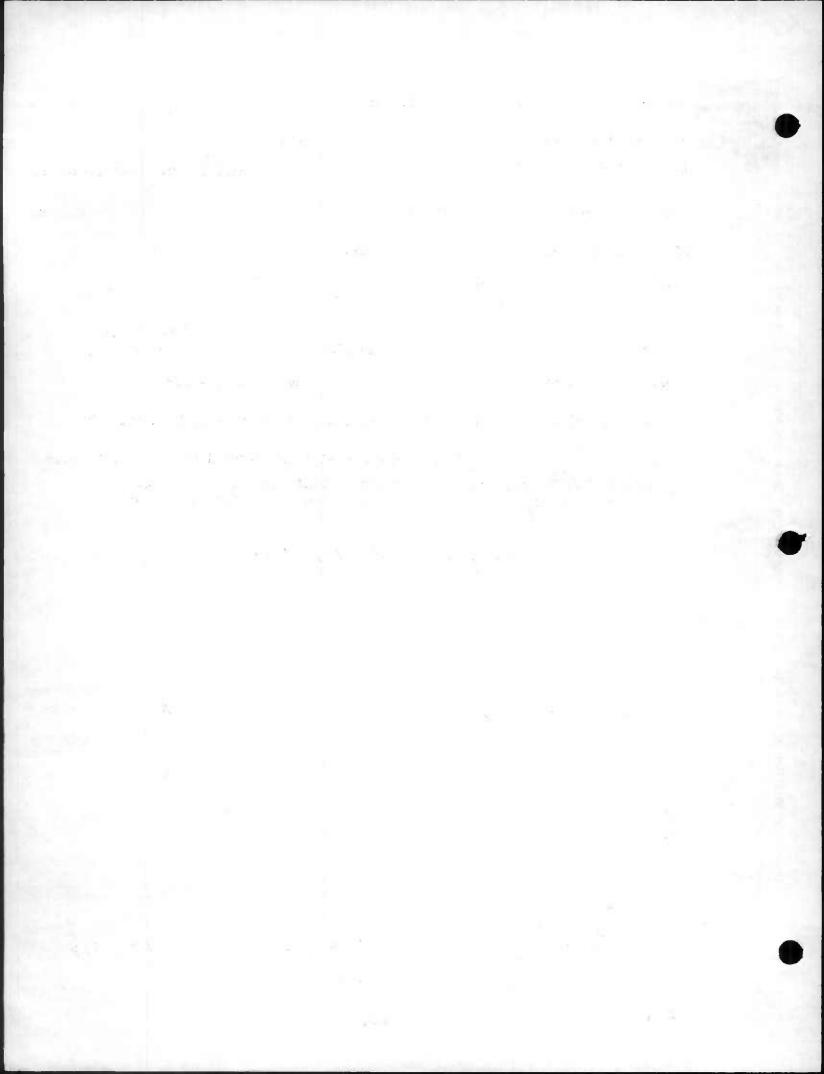


			*		Certifica	ate of	Death	10.0-1-15	Reg. No.	0 4	. / 0 0 0	
Phys /Me	ician dical	1. Decedent'e Neme (First, Middle, Last Jean Simmons Burc						2. Deta of D Month	17 267	Yeer 797	3. Time of Death	
Exar	niner	4a Facility Name (If not institution, give					4b. City, Town, or L					
Funn		Union Memorial Ho 5. Sociel Security Number 6. Se		(In yrs. lest bir		ler 1 Yeer		8. Date of 8 (Month, L		imore	plece (State or Foreigntry)	ın
Funer Direct			□M 2X0F		Yrs. Month	s Deys	Hours Min.	NOV.	3, 1926	Penn	isylvania	
p a		Usuel Residence of Decedent 10a. Stete 10b. County		10c. City, Tow	n or Location						10d. insida City Limits	_
tha Merylan 28a-f show	5		S 100								1 ☐ Yes 2 💢 No	
tha P	Director	Maryland Cecil 10e. Street end Number		Color		Zip Code			10g. Citizen of	What Cou	ntry?	
death with the Meryland ms 23s or 28s-f show		1 Balderston Lane				219	17		USA			
	Funeral	11. Marital Status	12. Wes Decedent E Armed Forces?		13. Was Dec	cedent of h	Hispenic Origin? (Sp pan, Mexican, Puarto	ecify Yes or N Rican, atc.)	o- 14. Rad Ble	ce - Americ	can indien, etc.	
20 rs after	by F	1 ☐ Never Merried 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	1 Yes 2 X No If Yas, Give Yeer or Dates:	0	1□ Yes	2 No	Specify:		Specif	y: wh	ite	
and 21215-0020 be filed within 72 hours after dea tel hygiene. d other then "netural; or items went, its wester Exerting		15. Decedent's Edu	ucation	16a.	. Decedent's Us	suel Occup	pation		16b. Kind of 8			
A1 - C-	Completed	(Specify only highest grad	Coltege (1-4or 5-	+)			pation during most of work od)	an g				
1 21 led wit hygiene nt, tre	Con	17. Fether's Nema (First, Middle, Last)	5	Re	gistere	d Nw	18. Mother's Nam	o /First Midd			VA Hospit	al
bre, Maryland 21215-0020 is 1 and 2 should be filed within 72 hours aft of Haelth and Mantel Hygiens 'natural', or other traumatic event, its Marital Education	o Be	William Fisher Si	mm a la f				Lillian		e, Meldell Sulliel	ne)		
Should Ma Mark	F	19a. Informent's Neme/Retetlonship (T		196	. Mailing Addre	ess (Street	t end Number or Rui		ber, City or Town	, State, Zip	o Code)	
Mand 2 and 2 and 2 and 27 is		Mark Burchard/Son		P	0 Box 3	57 (Chesapeak	e City.	Maryla	nd 21	915	
Ore, of Ha		20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ I	Removel from State	20b. Plece o cemete	f Disposition (A ry, cremetory o	leme of r other ple	ace)	Dete	20c. Location	- City or To	own, Stata	
Pag ment lant: h		4 Donetion 5 Othar (Specify,		St. M.	ark's C			-29-98	Peryvil	le, 1	Maryland	
Baltimore, Maryland; permit. Pages 1 and 2 should be filed Deperment of Health and Mariel by important: If Item 27 is marked other any injury or other traumatic event.	once.	21. Signeture of Funeral Service Licens					ass of Facility rd Funera	l. Home	P. A.			
~		esa. Pari 1. Enter the disease, or companion, or beart failure. List only o		the death De	111 S	. Que	een St.	Rising	Sun, Ma	rylan	d 21911	
Physicia	n	shook, or beart failure. List only o	ne ceuse on each line	e.	not ental the m	ode or dyr	ing, socii es cardiac	or respiratory	arrast,		Approximete Intarval Between Onsat and Death	
/Medic	al	Immediate Ceuse (Finel disease or condition	Des	0.000	Vack	F	Hyne				0-1301	
Examin		resulting in death)	a. 700	Due to (or es a	consaquence of	of):	11916				MAR	
p #	Jiner		b. Un	h ci	gnce	R					6 month	1
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		resulting in deeth) Last				.,						
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O a the	Physician/M	Part II. Other aignificant conditions co	ntributing to death but	t not resulting i	n the underlying	g causa gi	van in Pert I.				to the cause of death	
IS, P. as that it igned by be detected	by Ph							13	Yoo 2□ No	3 □ Pro	obably 4 Unknow	vn.
ords and sign								24a. We	s en eutopsy formad?	6/	Vere eutopsy findings veileble prior to	
2 8 8 8	plet			-				poi		CC	ompletion of cause f deeth?	
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of Vital F Physician: The this cartificeta	B	25. Wes cese referred to medical exeminer?	Hospitel:			C	26. Plece of Dee					
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	ition	1 Preature 5 Pending invastigation	28e. Date of Injury (Month, Day	Year)	Injury	28c. Inju Wo	ork?] Yes 2 □ No		,,			
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To the Hospital or within 24 hours effe To the Funeral Dir completely filled in	edical	29a. Certifier (Check only one) 2 Medical Example 2 Medical Exampl	sician: To the best of	exemination en	e, death occurre d/or investigeti	ed et the ti on, In my o	ime, date end plece, opinion, deeth occur	end due to the	e ceuse(s) and m e, date end piece	enner es s , end due t	steted. to the ceuse(s)	
o the o the	Med	29b. Signature and title	end menner stat	ted.	2	29c. Licen:	sa number		29d. Date sign	ad (Month,	, Dey, Year)	
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State of Maryland / Department of Health and Mental Hygiene

Physicia	ın	1. Decedent's Name (First, Middle, Rachel	Last) Ann		Ricc	derman		2. Dete of De Month	, Dey Ye	3. Time o	
/Medica	al				prec	ierman	the O're Town	Augus	t 26,199	8 02%	30
Examine	er	4a. Fecility Name (If not institution, 850 Frenchtown R	•	r)			4b. City, Town, or Elkton	Location of Deetr	4c. County of D		
Funeral Director		5. Social Security Number 222–28–6809	6. Sex 7. A 1 □ M 2 점 F	Age (In yrs. I	last birthday) Yrs.	If Under 1 Ye Months Da		8. Date of Bir (Month, Da Dec 1	9. 0 1942 We	Birthplace (Stete of Country) St Grove	or Fo
28a-f show	or	Usual Residence of Decedent 10a. Stete 10b. County MD Cecil			y, Town or Loc kton	ation				10d. Inside C	
3e or 28a	Funeral Director	10e. Street and Number 850 Frenchtown R	Road			10f. Zip Cod 2192			10g. Citizen of What	t Country?	
0,1	p	11. Marital Stetus 1哲Never Married 2回 Marrie 3回 Widowed 4回 Divorced	12. Was Deceder Armed Forces of 1 Yes 21 if Yes, Give Year or Dates	? No			of Hispanic Origin? (Suban, Mexican, Puerl	pecify Yes or No to Rican, etc.)	14. Race - A Bleck, V Specify:	American Indien, White, etc. White	
netur	Completed	15. Decadent's (Specify only highest Elementary/Secondary (0-12) 12	s Education grede completed) College (1-4o	r 5+)		ent's Usual Oc ind of work do O NOT use re Assembl	cupetion ne during most of wor ired) er	rking	Fiber/Cl.	oth	
merked other than matic event, the M	To Be C	17. Fether's Name (First, Middle, La George H. Bieder	•					me (First, Middle, E. Dilw	Maiden Sumeme) orth		
is mar		19a. Informent's Name/Relationshi					eet end Number or Ru				П
tem 27 other tr	***	Jeanne E. Arbeit 20e. Method of Disposition	er - Siste	20b. Pl	lace of Dispos	ition (Name of	urch Road	, Newark	, Delawar 20c. Location - City		
int: If i		1 ABurial 2 ☐ Cremation 3 4 ☐ Opnetion 5 ☐ Other (Spe		8	emetery, crem celawn		al Park	8/29/98	New Castl	e, Delaw	ar
Department of reein a Important: If item 27 is eny injury or other tra		21. Signature of Fundal Miles Frank C. Maye	nayer	A.			dress of Facility Ilikin Fur uPont Pkw			19720	
		23a. Part1. Enter the disease, or or shock, or heart failure. List or	omplications that cause nly one ceuse on each	ed the deeth line.						Approximet	e wee
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g physicial es the bur	ledicai	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last	c		r es e consequ						
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he ettending physicia hed for use es the bur	Physician/Medicai	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Part II. Other significant conditions Ouwi un	s contributing to death	Due to (or	es e consequ	ence of):	given in Pert I.	23b. Did	lobacco uae co <i>n</i> trib Yss 2 <mark>M</mark> No 3[pute to the cause	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Dete of Daeth 3. Tima of Deeth **Physician** Month Yaar Doris Garnetta Bledsoe 3:53 PM AUGUST 1998 /Medical 26 4a. Fecility Nama (If not institution, giva streat and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner I LAPLATA

If Under 1 Year If Undar 24 Hrs.

Months Days Hours Min.

January 3, 1921

| CHARLES | 9. Birthplaca (Stata or Foreign Country) | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Count CIVISTA MEDICAL CENTER 5. Sociel Security Number 7. Aga (In yrs. last birthday) 6. Sax 1□M 20F 249-22-3680 Yrs. Usual Rasidence of Decedant 10a Steta 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Director Charles Indian Head 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 22 Glymont Road 20640 USA Funerai 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: 13. Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 1 Nevar Married 2 Married 1 ☐ Yas 2 No Specify: Specify: White Completed by 3 X Widowad 4 ☐ Divorced 15. Decedent's Education (Spacify only highest grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) Propellent Operator Federal Govt. 17. Father's Name (First, Middla, Last) 18. Mothar's Name (First, Middla, Maidan Sumama) Be Welton Phillips Jessie Ruth Brown Phillips 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Patricia DeLozier/Daughter 2602 Dakota St. Bryans Road, MD 20616
20a. Mathod of Disposition (Nama of Deta 20c. Location - City or Town, Stata 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) 1 Burial 2 □ Cremetion 3 □ Ramoval from Stata Trinity Memorial Gar. 8/29/98 Waldorf, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funaral Sarvice Licansee 22. Neme and Addrass of Facility AREHART-ECHOLS FUNERAL HOME P.A. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory ariest, approximate shock, or heart failure. List only one cause on each line. Onsat and Death Immediata Causa (Final diseasa or condition rasulting in death) Dua to (or as a consequence of): Examiner Sequentially list conditions, if any, leeding to immadiata ceusa. Enter Undarlying Causa (Disaase or Injury that Initiated evants rasulting in daath) Last Dua to (or as a consequance of): Respitation Failure Physician/Medicai Dua to (or as a consequance of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Wara autopsy findings availabla prior to completion of causa of death? Completed 24a. Wes an autopsy performed? 1 ∏Yas 2 ∏ No 25. Was cesa raferred to medical axaminer? 26. Plece of Death (Check only ona) Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 Yas 2 No 1 Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Mennar of Death 28b. Tima of 28d. Dascribe how injury occurred 28c. Injury at Work? 5 Pending investigation Netural 1 ☐ Yas 2 No 2 Accidant 6 Could not be datarminad 3 Sulcida 28e. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 ☐ Homicida edicai Certifying Phyelcian: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es steted. 29e. Cartifiar (Check only one) 2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred et the time, date and place, and due to the ceuse(s) and manner stated. 29b. Signatura end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) Hunasi Kall 10 8/26/98. D-45642 30. Nama and address of person who completed causa of death (Item 23a) (Type, Print) CENNA MEDICAL CENTER, 7C POST OFFICE ROAD MAHADEVAPPA K. HUNASIKATTI MD. WALDROF, MARYLAND 20602 31. Data filed (Month, Day, Year) 32. Ragistrar's Signatura

Division of Vital To the Hospital or Attending Physician: within 24 hours eftar death.

To the Funeral Director: Aftar this certifica completely filled in by the funaral director, I

> State Registrar

AUG 28

Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at

Department of Health and Annial Hygiane. Important: If flem 27 is marked other than "natural", or harms nearly injury or other traumatic access.

Physician

/Medicai Examiner

physician s the burial

signed by the at d be detached for

paga 2 s certificata

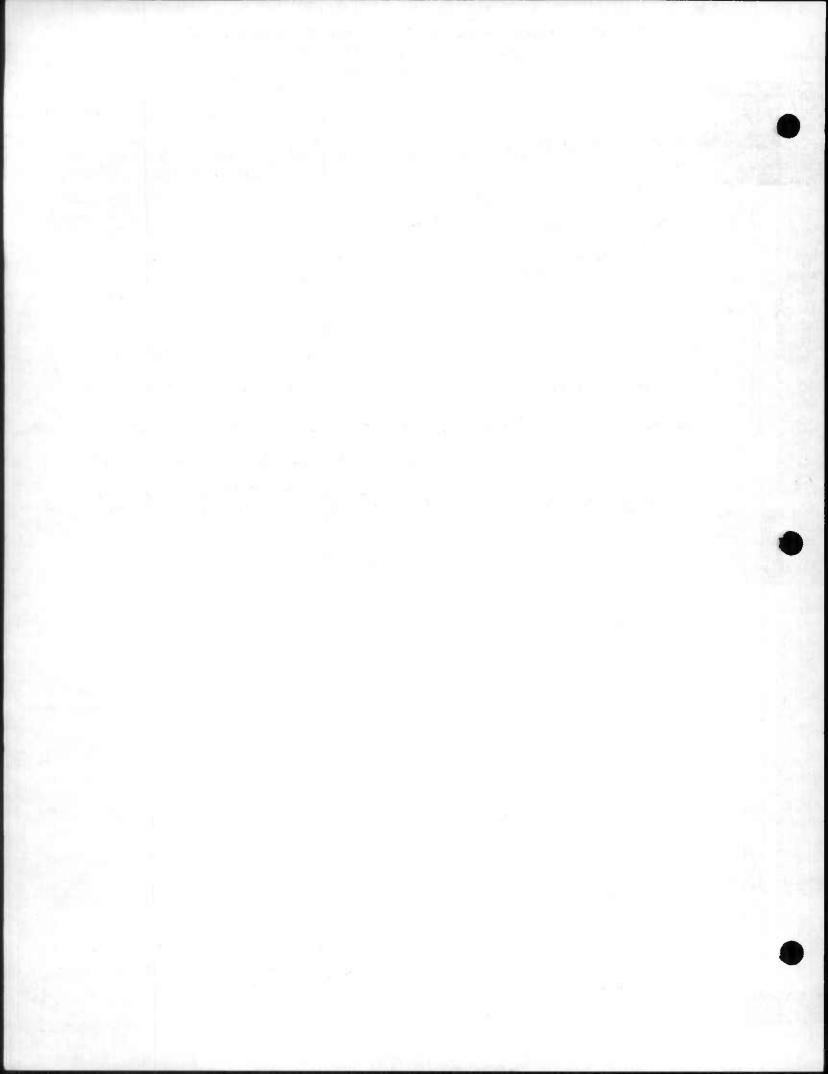
The law requires that the death certificate be axecuted

Box 68760,

P.O.

Records,

Baltimore, Maryland 21215-0020



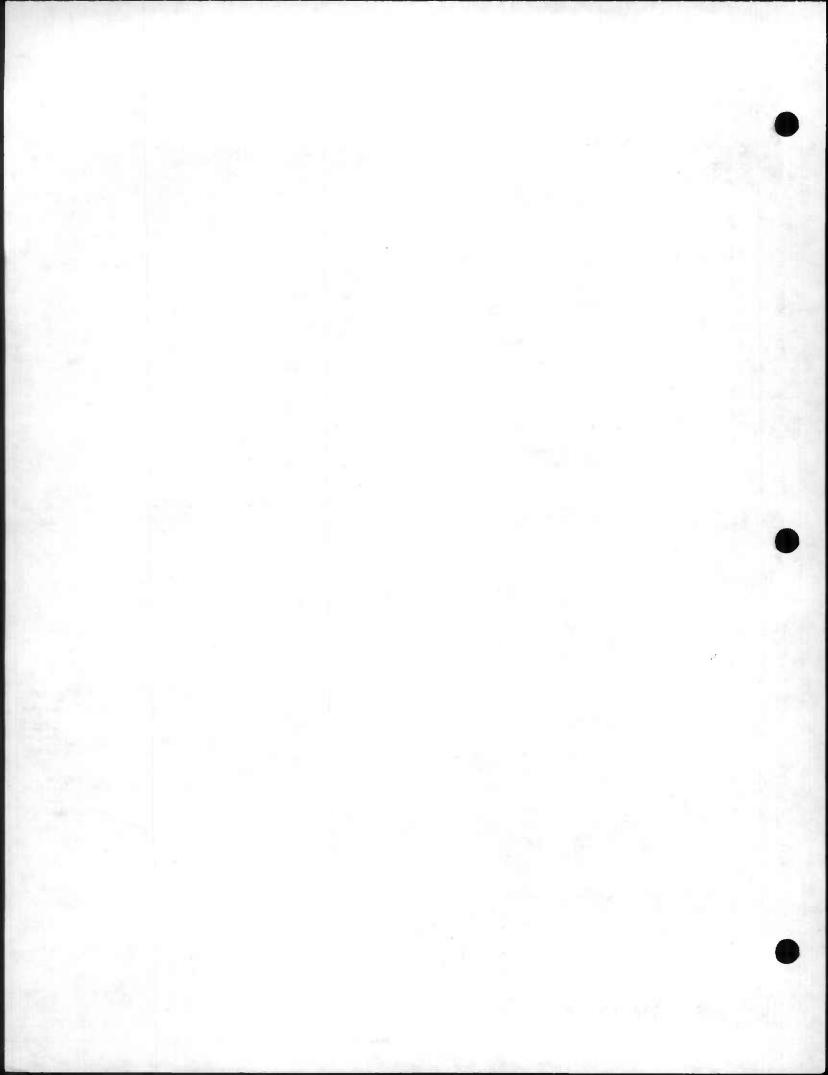
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Tima ol Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** EARL WILLIAM COX **AUGUST** 24 1998 5:50 AM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Sacred Heart Hospital Allegany Cumberland If Under 24 Hrs. Hours Min. 5. Social Security Number If Under 1 Yaar Birthplace (Stata or Foraign Country) 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** XXM 2□ F Months Days Oct. 20,1917 Director 217-14-4382 Maryland Usual Residence of Deceden the Menylend 10a State 10h County 10c. City, Town or Location 10d Inside City Limits ? Is marked other than "naturel", or items 23e or 28e-f show traumatic event, the Medical Examples must be notified at 1 ☐ Yes 2 No Director Mineral Keyser 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Peges 1 and 2 should be filed within 72 hours efter death with intent of Health and Mental hygiena.

It it item 27 is marked other than "naturel", or items 23e or intry or other traumatic event, its Mental Energy Constitution. Rt. 5, Box 490 26726 USA Funeral 12. Was Decedent Evar In U,S. Armed Forcas? 1 X Yes 2 □ No It Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yas or No-II Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - Amarican Indian, 11. Marital Status Black, Whita, atc. 1 Naver Married 2K Married 1 Yes 2 No Specify: Baltimore, Maryland 21215-0020 P 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Self Employed Timberman & Farmer 3 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middla, Last) 8 James Thomas Cox Virgie Mae Dawson 19a. Informant's Neme/Relationship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edith F. Cox/Wife Rt. 5, Box 490 Keyser, WV 26726 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Aug.27 1 Burial 2 Cremation 3 Removal from State permit. Pege Department of Important: If any injury or 4 ☐ Donation 5 ☐ Othar (Specify) Headsville Cemetery 1998 Headsville, WV 22. Name and Addrass of Facility 21. Signature of Funeral Service Licensee Rotruck-Smith Funeral Home ream 85 S. Main Street Keyser, WV 26726 23a. Part1. Entar the disease, or complications that caused tha death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Pulmoney disease /Medical Immediate Cause (Final disease or condition resulting in death) OGBOWS Examiner Examiner physician and the burial-transit law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence ot): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequance of): attending ph signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably þ 24b. Were autopsy tindings available prior to 24a. Was an autopsy Completed matome completion of cause of death? cartificata has t 1 ☐ Yes 2 ☐ No Physician: 25. Was case reterred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Inpatient 2 ER/Outpatient 3 DOA No 1 Yes Aftar this funeral 27 Manher of Dee 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Natural 2 Accident Hospital or Attending 5 Pending 1 Yes 2 No death. investigation after death 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, tarm, street, lactory, office building, etc. (Specify) 24 hours after Funeral Directles bletely filled in b 4 Homicide 1 A certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and dua to the cause(s) and menner as stated.
2 If Medical Committee, On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier edicai To the Hosp within 24 ho To the Fune completely fi (Check only one) and manner stated. 29d. Data signed (Month Day, Year) 29b. Signature and title AUGUST -1998 Name and eddress (Item 23a) (Type: of person with a Kichard Schmitt 31. Date tiled (Month, Day, Year) AUG 2 6 1998 Registrar

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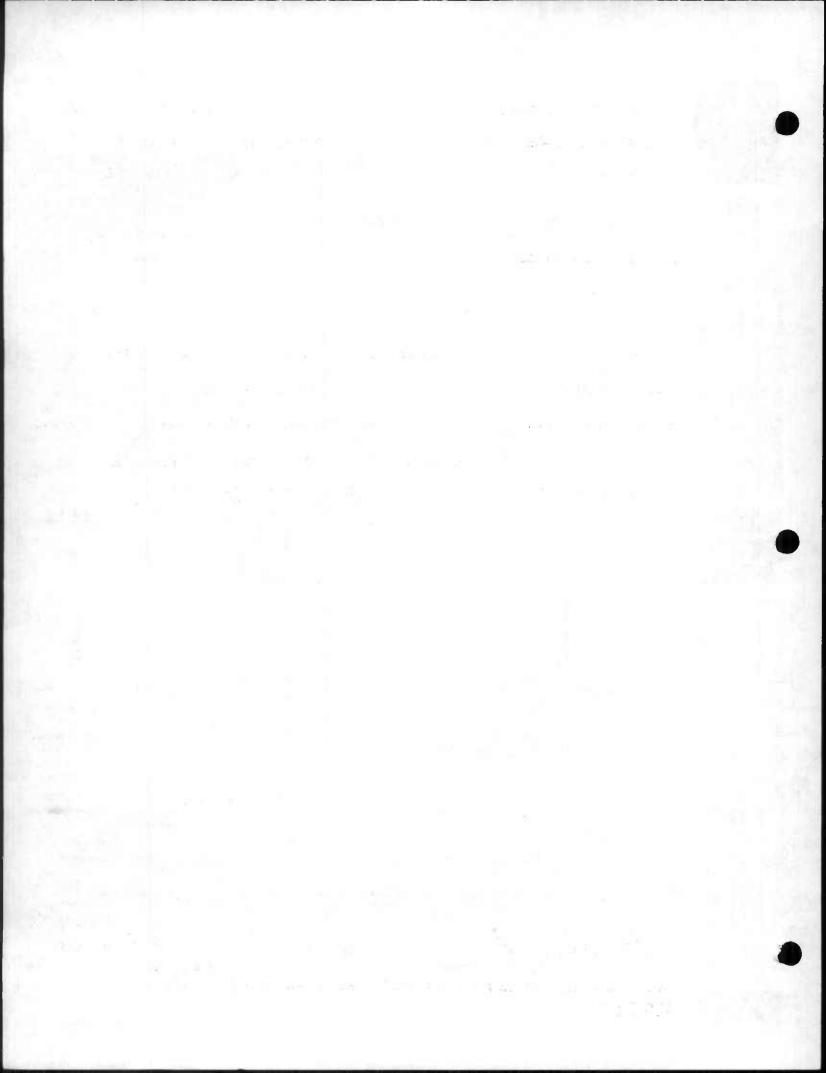
State of Maryland / Department of Health and Mental Hygiene

an	1. Decedent's Name (First, Midd	fle, Last)						2. Date of D		Maria	3. Time of Death
	MARY WINIFRE	ED CROS	SBY					AUGUST	20 1	Year 998 1	0:20 AM
al er	4a Facility Name (If not institutio					1	6b. City, Town, o	r Location of Dea			U.ZU AII
٠.	SACRED HEART	HOSPI	TAT.				CUMBERL	AND	ATTE	EGANY	
	5. Social Security Number	6. Sex	7. Ag	e (In yrs.		Under 1 Year	If Under 24 Hi	s. 8. Date of B			ce (State or Foreig
	212 74 1070 Usual Residence of Decedent	1 M	2 Tr	86	Yrs.	onths Days	Hours Mi	JULY	11 1912	MARY	LAND
	10a. State 10b. County	1		10c. Cit	y, Town or Location	on			-	100	d. Inside City Limits
25	MARYLAND ALL	EGANY		F	ROSTBURG						1 Yes 2 □ No
Director	10e. Street and Number				1	Of, Zip Code			10g. Citizen of N	What Country	y?
	9 BEALL STRE					21532			U.S.		
	11. Marital Status 1 Never Married 2 Mar 3 Widowed 4 Divorced	rried 1	/as Decedent rmed Forces? ☐ Yes 2 ☐ I Yes, Give A		If Ye	Decedent of H s, specify Cuba Yes 2 No	lispanic Origin? (an, Mexican, Pue Specify:	(Specify Yes or N erto Rican, etc.)	Blac	a - Americar ck, White, etc WHITE	
-	21	nt's Education	ear or Dates:		16a. Decedent	e Heuel Occur	etion		16b. Kind of Bi		elni
	(Specify only highe	est grade com	pleted)		(Give kind	of work done	during most of w	orking	100. Kind of Bi	35111055711100	sily
	Elementary/Secondary (0-12)	C	ollege (1-4or !	i+)	HOMEMA				Hom	0	
ŀ	17. Father's Name (First, Middle,	, Last)			11011211		18. Mother's N	ame (First, Middle	e, Maiden Suman		
l	TIMOTHY TAYLO	р удне	v				ETTA	(HAWKINS) ATHEV		
1	19a. Informant's Name/Relations				19b. Mailino A	ddress (Street			ber, City or Town,	State, Zio C	Code)
ı	MARY LYNN PEG							RG, MD 2			
	20a. Method of Disposition	O) NIL	IOL .	20b. P	laca of Disposition	n (Name of		Date	20c. Location -	City or Tow	n, State
	1 Donation 5 Other (5		at from State		emetery, cremeto			10/22/00	EDOCTE	IIDC N	m
ŀ	21. Signature of Funeral Service			FRU	STBURG M	me end Addre		8/22/98	FROSTB	UKG, P.	ID.
	0.00							DME, P.A			
+	220 Part Enter the disease of	Securior in	حري	the deet	60	WEST M	AIN STRE	EET, FRO	STBURG,		32 Approximete
l	23a. Part1. Enter the disease, or shock, or heart failure. List	t only one cau	use on each li	10.	i. Do not enter th	e illoue or uya	y, such as card	ac or respiratory	girosi,	10	nterval Between Onset and Death
l	Immediate Cause (Final										
ı	disease or condition resulting in death)	aS	SEPSIS	HEI I						24	HOURS
				1	r as a consequen	ce of):				101	
		b			EATITIS	- 0				124	HOURS
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			DUE TO (O	r es a consequen	De 01):					
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1				O) 01 800	r es e consequend	~ 017.					
	resulting in death) Last										
	resulting in death) Last	d				-				i	
		d	ing to death h	ut not ree	ulting in the under	ving cause ci-	en in Pert t	23h Dia	tobacco usa co	ntribute to 1	he cause of deeth
	Part It. Other significant condition	d	ing to death b	ut not res	ulting in the under	lying cause giv	en in Pert t.		_		he cause of death
				ut not res	ulting in the under	lying cause giv	en in Pert t.		I tobacco use co] Yes 2欠 No		
	Part it. Other significant condition DIABETES M.	ELLITE	S		ulting in the under	lying cause giv	en in Pert t.	1 = 248. We	Yes 2 No	3 Probe	bly 4 Unknown
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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uneral lirector		5. Sociel Security 214-05- Usual Rasidenca	-6498	Sex X□M 2□F	7. Age (In yrs	. lest birthday) Yrs.	If Under 1 Months	Days	If Undar 24 Hr Hours Mir	. (Month,	Birth Day, 1	1916	9. Birthpl Count MD	ace (Stete try)	or Fore
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or 28)Ire	10e. Street end N					10f. Zip (Code			100	g. Citizen of V	Whet Coun	try?	
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Importan any Injur once.		Mylac	holas	120	avo	Wi	Scarp	ell	i Funerand, MD	21502					
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	j C	uneral irector		-
Baltimore, Maryland 21215-0020	permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland	Department of result of Montal rygens. Impropriately, or items 23a or 28a-f show any injury or other traumatic event, the Medical Exeminer must be notified at once.	To Be Completed by Funeral Director	
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al Records, P.O. Box 68760,	The law requires that the deeth certificate be executed	cate has been signed by the ettending physician end page 2 should be deteched for use es the buriel-transit	Completed by Physiclan/Medical Examiner	

325-32-7501

CHARLES CARDER

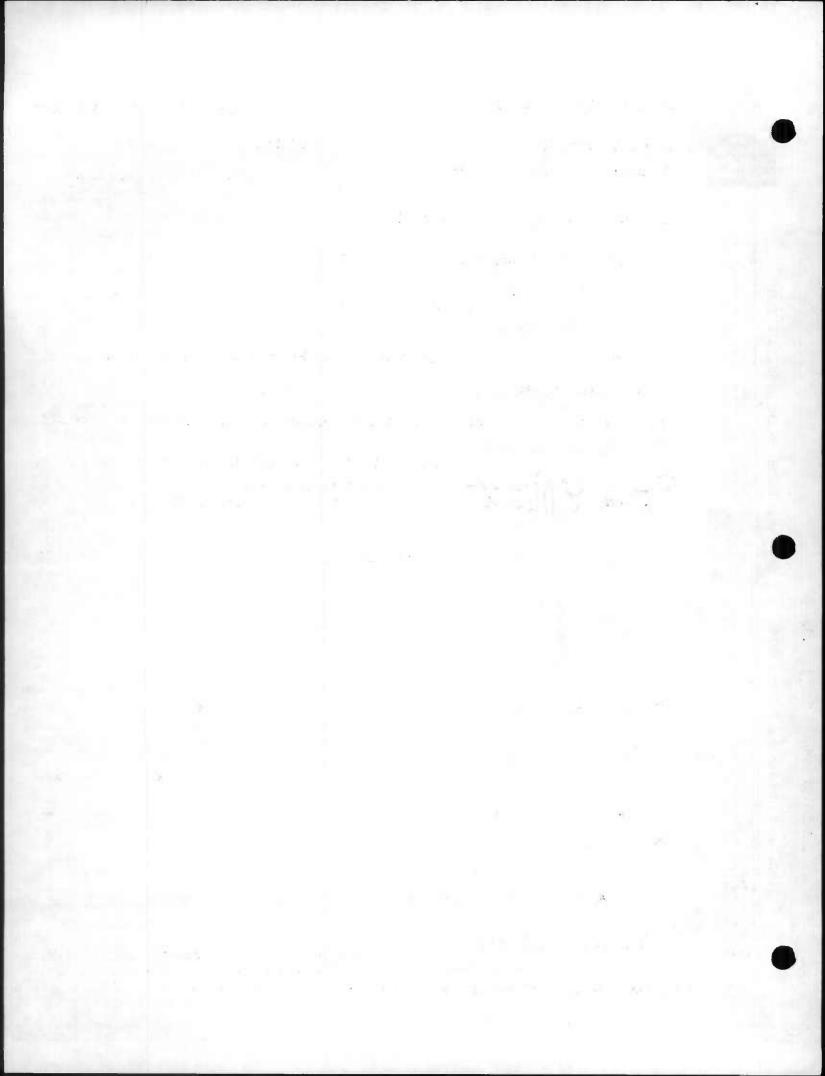
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Physic /Med		CHARLES DELMAI	R CARDE	R				A	ugust	12, 199		:10	A.M.
Exami		4a Facility Neme (If not Institution	, give street end r	num <i>ber)</i>			4b. City, To	own, or Loca	tion of Deeth	4c. County	of Death		
4.7		MEMORIAL HOSPI	ral_					ERLAND			EGANY		
Funera	1	5. Social Security Number 325-32-7501	6. Sex 1, M 2□ F	7. Age (In yrs 58	. lest birthday, Yrs.	Months Da	ear If Under tys Hours	Min. 8	Month, Dey	Year)	9. Birthpla	ace (Ste	te or Foreign
Director			XX 2	30	115.			JA	N 4 1	940	MARY1	LAND	
and **		Usual Residence of Decedent 10e. State 10b. County		10c. C	ity, Town or L	ocafion					10	d. Inside	City Limits
Many	0	MARYLAND ALLE	GANY	CI	JMBERLA	AND						1 🗆 Y	es XXNo
the 128s	Director	10e. Street and Number				10f. Zip Coo	de		1	0g. Citizen of V	Vhat Count	ry?	
with with		1/012 PRICE HO	TOTT DOA'	D C E		215	:02			U.S.	\		
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2 should be end Mental is marked o	2	DANIEL EDWARD			401 11	ing Address (St		SCHA		Cit T-	Cinta Ti	Carlos	
2 2 2		19a. Informant's Name/Relationsh	np (Type, Pnnt)	WIFE		BRICE				CUMBERL			AND
		NANCY CARDER 20a. Method of Disposition				osition (Name of				20c. Location -			
0 80= 5		1 Burial 2 Cremation		m Stafe	cemetery, cre	metory or other	plece)	1					
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		shock, or heart failure. List	only one cause on	each line.	itii. Do not en	iter the mode of	dynig, such a	o darona c or r	ospilatory arr	001,		Interval	Between nd Death
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eeth certificate be executed ettending physician end I for use es the buriel-transit	MVae		d							-	1		
• 0 0 0	Physician	Part II. Other significant condition	ns contributing to	death but not re	sulting in the	underlying caus	e given In Part	l.	23b. Dld to	bacco use co	ntribute to	the cau	se of death?
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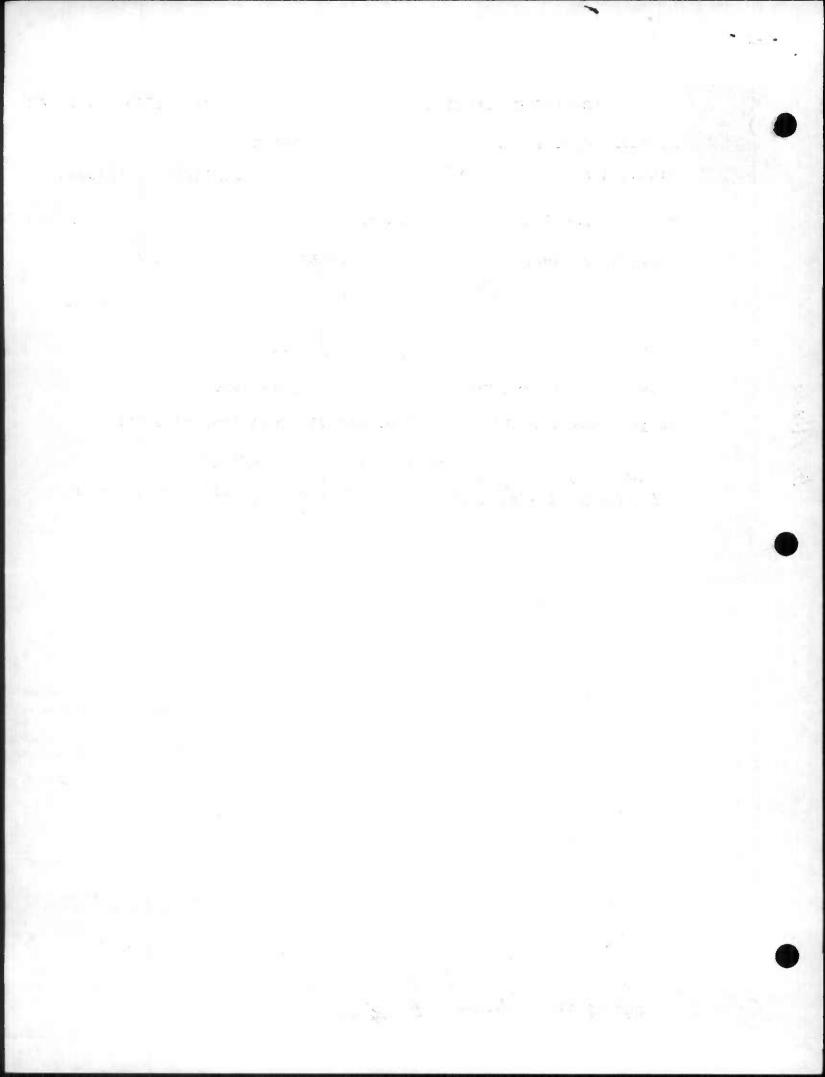
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5		30. Name and address of person who completed cause of ATKINS MD 1104	of deeth (Item 23)	a) (Type, Pi	rint) Az Di	sue E	solu n	10 2	1800	1
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permit. Pages 1 and 2 should be filed within 72 hours eftar deeth with the Department of Health end Mental Hygiena. Important: If tem 27 is marked other than "natural", or items 23a or 28a any Injury or other traumatic event, tra Medical Examiner must be not once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

physician end the burial-transit The law requires that the death certificate be axecuted Division of Vital Records, P.O. Box 68760, BS attanding F signed by the a certificate hes b lirector, page 2 s or Attending Physician: after death. Director: After this certifica funeral To the Hospital or Attervitin 24 hours after dea To the Funeral Director completaly filled in by the

1. Decedant's Nama (First, Middla, Last) Month 18, 1998 AUG. 2248 PM David Carin 4b. City, Town, or Location of Daeth 4c. County of Death 4e Fecility Name (If not institution, giva street and number) WESTERLY & EDWARDS ROAD **POOLSVILLE** MONTGOMERY If Undar 1 Yaar If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 5 Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplace (Stata or Foraign Country) 1 M 2 □ F Yrs. 32 May 20,1966Washington, 217-90-0297 Usual Rasidence of Decedant 10d. Inside City Limits 10a. Stata 10b. County 10c. City. Town or Location 1 Yas 2 No Rockville Maryland Montgomery 10g. Citizen of Whet Country? 10f. Zip Coda 10e. Street and Number Dire 1515 Templeton Place 20852 U.S.A. Funerai 12. Wes Decedent Ever in U,S. Armed Forcas?
1 ☐ Yes 2 ☐ No Was Decedent of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, etc.) 14. Race - Amarican Indian, Black, Whita, etc. 1 Navar Marriad 27 Married 1 Yas 2 No Spacify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usuel Occupation (Give kind of work dona during most of working lifa. DO NOT use ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highest grade completed) Private Elamentary/Secondary (0-12) Collega (1-4or 5+) Accountant Practice 18. Mothar's Nama (First, Middla, Maiden Sumame) 17. Fathar's Nema (First, Middla, Last) Roberta Taple Phillip Carin 19b. Malling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) 19a. Informent's Name/Relationship (Type, Print) 1515 Templeton Pl.Rockville, MD 20852 Jamie Cheryl Carin/Wife 20b. Place of Disposition (Nama of cematary, crematory or othar place) 20a. Mathod of Disposition Deta 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata 4 ☐ Donetion 5 ☐ Othar (Spacify) Judean Memorial 8/21/98 Olney, MD 22. Nama and Addrass of Fecility 21. Signatura of Funaral Sarvice Licansaa MOD544 Ives-Pearson Funeral Home 2847 Wilson Blvd. Arlington, VA 22201 Approximata Intervel Batween Onset and Deeth Wall flede X 23a. Part1. Entar tha disaase, or complication, that causad tha daeth. Do not enter the mode of dying, such as cerdiac or raspiratory arrast, shock, or haart failure. List only one codes on each line. Immediata Causa (Final disaasa or condition rasulting in daath) Cutting Wounds of Neck Examiner Sequantially list conditions, if any, laading to immadiata ceusa. Entar Undarfying Cause (Disaasa or injury that Initiated avants rasulting in daath) Last Dua to (or as a consequence of): Physician/Medicai Dua to (or as e consaquenca of) 23b. Did tobecco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings eveilable prior to complete on of ceusa 24a. Was an autopsy Completed 1 Yas 2 No 1.5 Yes 2□ No 25. Wes cese refarred to medical axaminar? 26. Placa of Deeth (Check only ona) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Residence 6XX thar (Specify) AT SCENE 2 1X Yas 2 No 28d. Describe how injury occurred 27. Mannar of Death 28c. injury at Work? Certification: subject ent set 1 Natural 5 Panding 1 ☐ Yas 2 HNo invastigation 2 ☐ Accidant 28. Location (Street and Number or Rural Routa Number, Edity or Town State) Read Pagles ville Hd

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State Registrar

31. Data filad (Month, Day, Yaar) AUG 25 1998

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W 32. Registrar's Signature Sporks

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State of Maryland / Department of Health and Mental Hygiene 98 97364

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/Medical	4a Fecility Name (If not institution, give		OHDII DI		4b City T	own or Lo	AUGUST cation of Deeth	24, 19		12:0	0noon
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	Usual Residence of Decedent										
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cto		George's	Ft. Was	hington						1 X Yes	2 L No
r items 23a or 25a-f a diner must be notified Funeral Director	10e. Street end Number 902 Wrigley Pla	ice		10f. Zip Code 207			10	Og. Citizen of V United			
ner ner	11. Marital Status	12. Was Decedent Ever	in U,S. 13.	Was Decedent of If Yes, specify C	f Hispenic O	rigin? (Spe	ecity Yes or No-		e - America k, White, e		
by by	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 X Yes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 2 🖔 N			Thousan, order,	Specify			
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n and fal-transit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due	to (or as a conse	equence of):							
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Within 24 notes and destru- To the Funeral Director: A) completely filled in by the fr Medical Certification		nyaician: To the best of my miner: On the basis of exer end manner stated.)
within 2 To the comple	29b. Signeture and title of certifier			29c. Lic	ense number		2	9d. Date signe	d (Month, i	Day, Year)	
20	> J. Pert	aner, M.	0.		O.C.M.	Ε.	AU	JGUST 2	5, 19	98	
	30. Name and eddress of person who	completed cause of deeth		n Street	, Bal	timor	e, Mary	land 21	201		
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Dey **Physician** 19, 1998 AUG. 8:30 A.M. CHU FANG /Medical 4b. City, Town, or Location of Deeth 4e Facility Neme (If not institution, give street end number) 4c. County of Deeth Examiner **BETHESDA** MONTGOMERY SUBURBAN HOSPITAL if Under 1 Yeer | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (Stete or Foreign Country) **Funeral** 1□M 2♥F Months Deys Hours 579-70-5016 71 Yrs. SEPT. 6, 1926 YIXING, CHINA Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10e. Stete 10b. County 10c. City. Town or Location 1 ¥ Yes 2 □ No KENSINGTON MONTGOMERY MARYLAND Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? an "naturel", or items 23a or Medical Evament must be a U.S.A. 20895 4018 BYRD ROAD permit. Pages 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hygiana. Important: If item 27 is marked other than "naturel", or items 23a any injury or other traumatic event, the Medical Examiner must budge. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. 11. Meritel Stetus 1 Never Married 2 Married Specify: ASIAN 1 Yes 2 No Specify: P 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Bueiness/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) DATA ENTRY VERIFIER COMPUTER 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) UNKNOWN UNKNOWN YIN 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) 3757 MADISON LANE, FALLS CHURCH, VA 22041 ROSE CHU DAUGHTER 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 8/22/98 ROCKVILLE, MD PARKLAWN MEMORIAL PARK 21. Signeture of Funeral Service Licensee 22. Neme end Address of Facility
JOSEPH GAWLER'S SONS, INC. 5130 WISCONSIN AVENUE N.W., WASHINGTON, D.C. 20016 23a. Pert1. Enter the dishase, or complexitions that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart failure. List only only ease on each line. Approximete Intervel Between Onset end Deeth **Physician** Cardio pulmonary Immediete Ceuse (Final disease or condition resulting in deeth) 20 hours /Medical Examiner aP hours panneatitis Examine certificate be axecuted Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): physician ar Box 68760. Physician/Medical Due to (or es e consequence of): use a 23b. Did tobacco usa contribute to the cause of death? Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert 1. 3 Probably 4 Unknown 1 Yes 2 No hypotension g 24b. Were eutopsy findings evailable prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed 20 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical exeminer? 26. Plece of Deeth (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA this 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? Certification: 12 Neturel 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigetion 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide Certifying Phyeicten: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and menner es steted.

| Medical Examiner: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner stated. 29a. Certifier edical completaly (Check only one) 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signeture, end title of certifier It I viete Chiong, man pho D34569 August 19.1898 20 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 9707 Medical center Dr., Suite 320, Puckville, my 20850 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture

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Registrar

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			Certificate of	Death		Reg. No.	21000
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aminer eral ctor	HEBREW HOME OF GREA	TER WASI	HINGTON	OCKVIII. If Under 24 Hrs. Hours Min.	8. Dete of Bir	MONT	GOMERY 9. Birthplece (State or Foreign Country)
	Usuel Residence of Decedent 10e. Stete 10b. County	10c. City, Town	n or Location				10d. Inside City Limits
or set	MD MONTGOMERY	Too. Oily, Town	ROCKVI	LLE			1 ☐ Yes 2 ☑ No
rect	10e. Streef and Number		10f. Zip Code		- 1	10g. Citizen of V	Vhet Counfry?
1 0	6121 MONTROSE ROAD		20	852		USA	
Examiner must be notified at by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Wes Decer Armed Ford 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 3	No	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispenic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	Blec	e - Americen Indien, kk, White, etc. :: WHITE
rt, the Medical Exa Completed by	15. Decedent's Education (Specify only highest grade completed)	16e.	Decedent's Usuel Occup	during most of work	ing	16b. Kind of Bu	usiness/indusfry
	Elementery/Secondary (0-12) College (1-	4or 5+)	life. DO NOT use retired	d)		MAN	AGER
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To Be	AARON R. COHEN				AH GER		
-	19a. Informent's Neme/Relationship (Type, Print)	19b	. Meiling Address (Street	end Number or Rure	el Route Numb	er, City or Town,	Stete, Zip Code)
	LINDA SOLOMON / DAUG	HTER	10013 CLE	ARSPRING	G RD.	DAMASC	US,MD.20872
	20a. Method of Disposition 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from S	comete	f Disposition (Neme of ry, cremetory or other plea	ce)	Dete	20c. Location -	City or Town, Stete
once.	4 Donetion 5 Other (Specify)	KING	DAVID MEM	GARDEN	5 8/24	/98 fa	11s church
8	21. Signefure of Funeral Service London		22. Neme end Addre			DIDECE	T 0 11
8	1		EDWAED S	KVILLE		ROCKVI	
	23a. Part1. Enter the disease, or complications that ca shock, or heart failure. List only one ceuse on ee	used the death. Do i	nof enfer the mode of dyin	ng, such es cerdiac	or respiretory e	rrest,	Approximete Intervel Between
1	Shock, of heart failure. List only one ceuse on ee	GIT IIITO.					Onset end Deeth
п	Immediate Cause (Final disease or condition	YOCARDIN	AL IN	PARCTIO	N		IDAY
	resulting in death) 9.	Due to (or as e	consequence of):				
ine	b						
Examiner	Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury c	Due to (or es e	consequence of):				
dicai E	cause, Enter Underlying Cause (Disease or injury that initieted events	2					
a)	resulting in death) Lest	Due to (or es e c	consequence of):				
2	d	- 3					
Physician/M	Pert II. Other significent conditions contributing to dea	ath but not resulting In	n the underlying ceuse giv	ven in Pert I.	23b. Dld	tobacco uae cor	ntributa to the causa of death
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by	DOMENT	,					T
Completed					24e. Wes	en eutopsy ormed?	24b. Were eutopsy findings eveilable prior to
ple						,	completion of cause of deeth?
Con					1 🗆	Yes 2 No	1 ☐ Yes 2 ☐ No
Be (25. Was cese referred to medicel exeminer?			26. Plece of Deet	h (Check only	one)	
10	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ In	pafient 2 ER/Ou		QZ Nursing Ho	me 5 Res	dence 6 □Oth	er (Specify)
tion:	27. Menner of Deeth Naturel 5 Pending (Month) 2 Accident investigation	Injury Dey Year) 28b. 1	Time of 28c. Injury Wor	y et rk? Yes 2 □ No	28d. Describe	how injury occur	red
Certification:	3 ☐ Suicide 6 ☐ Could not be	of Injury - At home, fe g, etc. (Specify)	arm, street, fectory, office			Street end Numb wn, Stete)	per or Rural Route Number,
edical C	29a. Certifier (Check only one) Certifying Physician: To the barence on the barend menning one)	sls of examinetion en					
Medical Certification: To Be	29b. Signeture end title of certifier		29c. Licens	se number		29d. Date signe	d (Month, Dey, Year)
	P. Talwar, M.D.		D 3	6552		AUGUST	23 1998
	30. Name end eddress of person who completed cause	of deeth (Ilem 23a)	(Type, Print)				
	P. TALWAR 6121	MONTRE		ROCK	VILLE	MD. 2	20852
		gistrar's Signeture	1				
State							

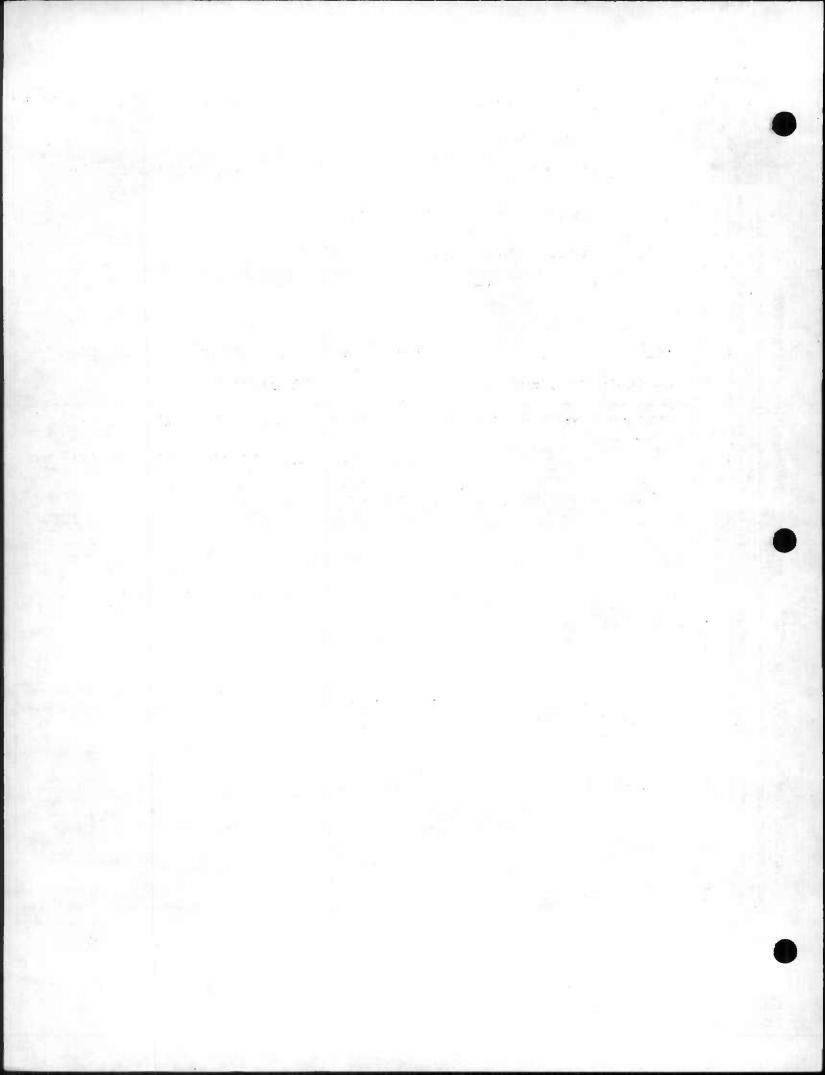
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death AUGUST Day 4 , **Physician** 1998 09:00 AM CRAWFORD SAMUEL /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner HOWARD Lorien Nursing Home COLUMBIA If Under 1 Year | If Under 24 Hrs. 8. Dale of Birth (Month, Day, 5. Social Security Number 9. Birthplaca (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Maryland 1⊠M 2□F Yrs. Jan.6,1914 218-14-7867 84 Director **Usual Residence of Decedent** 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No MD Howard Director Simpsonville 28a-f 2 10a. Street end Number 10f. Zip Code 10g. Citizen of What Country? na 23a or must be 8034 Harriett Tubman Lane 21150 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2€TNo If Yes, Give Year or Dates: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Bleck, White, etc. Pages 1 and 2 should be illed within 72 hours after nent of Health and Mental Hygiene.

ant: if Item 27 is marked other than "natural", or its ury or other traumatic event, the Medical Examins 1 Never Married 2 Merried Specify: Black Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ØNo Specify: p 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4th Heavy Equipment Operator Construction 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Benjamin Crawford Florence Rose 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 2 115 0 19a. Informant's Neme/Relationship (Type, Print) 8034 Harriett Tubman Ln., Simpsonville, MD Lillie M. Crawford (Wife) 20b. Placa of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removel from State Department of important: If any injury or 8/28/98 4 ☐ Donation 5 ☐ Other (Specify) Locust Church Cem. Simpsonville, MD 21. Signature of Funerel Service Licenses 22. Name and Address of Fecilit SNOWDEN FUNERAL HOME, P.A. 20850 ROCKVILLE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediete Cause (Final 5 minula disease or condition resulting in death) Examiner Examiner ear burlai-transit or Attanding Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): pue attending physician Box 68760 Physician/Medical the Due to (or es a consequence of): for use es signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown Serale Division of Vital Records, þ 24a. Wes an autopsy performed? 24b. Were eutopsy findings available prior to pege 2 ahould Completed peeu men completion of cause of deeth? certificata has lelo 1 Yes 20100 1 Yea 20 No director. Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? After 5 Pending investigation s after death. 1 Yes 2 No 2 Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 6 Could not be Placa of tnjury - At home, farm, street, fectory, offica building, etc. (Specify) 2 4 Homicide filled in To the Hospital of within 24 hours af To the Funeral Di Completely filled is 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner es stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 8 25 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14333 AURE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 2 6 1998 Registrar

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State of Maryland / Department of Health and Mental Hygiene

		Decedent's Name (First, Middla, Las	st)	- 30 10	Certificate of	Death	1	Reg. No.	8 2	3. Time of the oth
Physic /Medi		Cletus	Eugene	Cool			August	19 ^{Day} 199	8 Year	2:15pm
Exami		4e. Facility Name (If not institution, give 910 Trayer Avenu				4b. City, Town, or L Sykesvi	ocation of Death	4c. County	of Death	
Funeral Director		5. Social Security Number 219–36–1888	ex 7. Age XMM 2□ F	(In yrs. last bir	thday) If Under 1 Year Months Deys		8. Date of Birt (Month, Day May 29	h v, Year) 1921	9. Birthpi Coun MD	lace (Stata or Foraign try)
pun *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Location				10	0d. Inside City Limits
ne Maryli 8a-f sho	ector	Md Carrol	1	S	ykesville					1 ☐ Yes 2X No
oth with the 23a or 2	rai Dire	910 Trayer Aven	ue		10f. Zip Code 2178	34		10g. Citizen of V USA	Vhat Coun	try?
Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filled within 72 hours efter deeth with the Maryland Dependment of Health and Mentel Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumetic avent, the Medical Examere must be notified at once.	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E- Armed Forces? 1 XYes 2 ☐ No If Yes, Give Year or Dates:		13. Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 【▼No		pecify Yes or No- Rican, etc.)		e - Americo ok, White, o white	etc.
72 he	eted	15. Decedent's Ed (Specify only highast grad		16a.	Decedent's Usuai Occu (Giva kind of work dona lifa. DO NOT usa retire	pation during most of work	king	16b. Kind of Bu	usiness/ind	lustry
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and the filed nital Hygied other avent, is	Be	17. Father's Name (First, Middla, Last) George Joseph Coo	1 -			18. Mother's Nam	ne (First, Middla, Geneviev			
Maryland nd 2 should be file lith end Mental Hy 27 is merked other traumatic avent	To	19a. Informant's Name/Relationship (7 Bertie M. Cool (sp		19b 91	. Mailing Address (Stree	t and Number or Ru	ral Routa Numbe	or, City or Town,	Stata, Zip	Coda)
Baltimore, semit. Pages 1 ar Deportment of Hear mportant: If Item in the Interior or othe Mice.		20a. Method of Disposition 1 Burial 2 □ Cremetion 3 □ 4 □ Donation 5 □ Other (Specify		20b. Piace of camatar	Disposition (Name of y, crematory or other placen Memoria	al 8-	Date -22-98	20c. Location - Finksbu		
Balti permit. Depertm Imports any Inju		21. Signature of Funeral Service Licens Page Harakt	S00		22. Name and Addr	Ha	aight Fu			Chapel
		23a. Part1. Enter the disease, or comp shock, or heart feilure. List only of		he death. Do r					T	Approximate Intervei Between
Physician /Medical Examiner	er	Immediate Cause (Final disease or condition resulting in deeth)	a. Met		fic Ce	mee				Onset and Death
cords, P.O. Box 68760, requires that the death certificate be executed seen signed by the ettending physician and chould be detached for use as the burial-transit	Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in death) Last	. Deh	that	consequence of):					
Box death cert ettending	iciar	Part II. Other algnificant conditions co	intributing to dooth but	not requiting in	the underlying access of	ion in Bost I	COD DIA			the cause of death?
dS, P.O. Bi	Phys	Tarin Only algunous Continue Co	initioding to death out	not resulting in	i the underlying cease gi	ven in Fait i.				ably 4 Albinknown
Records, ne lew requiras th s has been signes age 2 should be d	Completed by						24a. Was	an autopsy med?	eva	ore autopsy findings ailable prior fo appletion of ceuse
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	To Be	examiner?	Hospitai: 1 🗆 Inpatient	t 2□ER/Ou	tpatient 3 DOA Ot	han	ome 5 Resid		er (Specifu	()
ion of ading Physith.: After this e funeral di		27. Menner of Death 1 Naturei 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day		ime of 28c. Injury	ny at ink?] Yes 2 □ No	28d. Describe h	now injury occurr	red	
Division or Attending after death. Director: After d in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	y - At home, fa (Specify)	rm, street, factory, office		28f. Location (S City or Tow	Street and Numb m, Stata)	er or Rura	Route Numbar,
Division To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edicai C	29a. Certifier (Check only one) 1 Certifying Phy 2 Medicel Exemi	rsician: To the best of Iner: On the basis of e end menner state	xaminetion and	, death occurred at the ti	me, date end plece, opinion, death occur	end due to the orred at the time, or	ceuse(s) and ma date and place, o	inner as st end due to	ated. the cause(s)
To the within To the comp	Me	29b. Signature and title of certifier	L's	uhe.	29c. Licen	se number		29d. Date signed		
		30. Name and address of person who c	ompieted cause of dea	ath (ttem 28a) (Type, Print Shah	nida Sidd:	iqi M.D		701	
Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar	's Signature	1 110	42746		~ (10	Τ
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Physic /Medi		Kathryn Ellen DeR	osa					Month August	Dey 15	Yeer 1998	5:20 PM
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3-11		Memorial Hospital					Cumberland	d	Al	legany	
Funeral Director		234-27-7128	Sex 7. Age 1	e (In yrs. last bii	Yrs. If Under 1 Months	Year Deys	Hours Min.	8. Dete of Bi (Month, D 03-Sep	irth ey, Year) -84	9. Birthpi Count West	ace (Stete or Fo try) Virginia
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He H	to	Maryland Alle	gany	Frostbur	a						1 K) Yes 2 □
or 282	Director	10e. Street end Number	Avenue		10f. Zip (Code			10g. Citizen of	Whet Count	try?
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*neturel", or items 23a or 28a-f show	by Funeral	11. Maritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decadent E Armed Forces? 1 ☐ Yes 2 ☑ N if Yes, Give Yeer or Detes:		13. Was Decede if Yes, specif		dispenic Origin? (Sp an, Mexicen, Puerto Specify:	ecify Yes or No Rican, etc.)		ce - America ck, White, e	etc.
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and Mental is marked o eumatic eve	TOE	Norman DeRosa					Patty Ic	e			
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Department Important: If any injury o		21. Signature of Funeral Service Lic	Duris	_	22. Name end Durst Fun		ess of Fecility I Home, 57 Fi	rost Ave.	, Frostburg	, MD 2	1532
nysician Medical kaminer	iner	Immediete Ceuse (Finel disease or condition resulting in deeth)	е		Contusi	on.				1	22 hour
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within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certification:	2\(\times\) Accident 3 \(\times\) Suicide 4 \(\times\) Homicide	OB Place of Injur	ry - At home, fe	rm, street, factory,			28f. Location (City or To	(Street end Numl wn, Stete) St. Fr	ber or Rural	Route Number,
within 24 hours after d To the Funerel Direct completely filled in by	edical C	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of miner: On the bests of end menner stet	examinetion en	, death occurred et dor Investigation, in	the tir	ne, dete end plece, pinion, deeth occurr	end due to the	ceuse(s) end m	anner as ate	sted.
To the	Me	29b. Signature and title of certifier	1		29c. l	Licens	e number		29d. Date signe	d (Month, E	Day, Year)
5		1. 1	and -		D	09	157		Aug	15, 1	L998
NUS Sta	te	Paul Snow, M 31. Dete filed (Month, Dey, Yeer) AUG 1 8 1998	completed cause of de D 124 32. Registrar				erland,	MD 21	.502		

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Dev Yeer **Physician** MARGARET JANE DORMAN AUGUST 9 1998 7:00 AM /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street and number) 4c. County of Death Examiner SACRED HEART HOSPITAL CUMBERLAND ALLEGANY If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Dev. Year) Birthplece (Stete or Foreign Country) **Funeral** Days Min 1 M 2 X F Months Hours Yrs. 220 16 2620 92 JUNE 7 1906 Director MARYLAND Usual Residence of Decedent the Marylend 10d. Inside City Limits 10e Stete 10h County 10c. City, Town or Location r 28a-f show show 1 ☐ Yes 🎾 No Directo MARYLAND ALLEGANY MT. SAVAGE 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? with "naturel", or items 23s or 14708 MT. SAVAGE ROAD, NW 21545 U.S. Funerai Pages 1 and 2 should be filed within 72 hours efter death nant of Health end Mental Hygiena. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 1 No if Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Bleck, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: WHITE þ 3 Widowed 4 ☐ Divorced r then "nature Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elamantary/Secondary (0-12) Coltega (1-4or 5+) COOK PUBLIC SCHOOL event, II 18. Mothar's Neme (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) 7 is marked of traumatic ever LAWRENCE WINEBRENNER FLORA MARTENS 19b. Malling Addrass (Street end Number or Rurel Route Number, City or Town, State, Zip Coda) 19a. Informent's Neme/Relationship (Type, Print) MAXINE LEAVITT / DAUGHTER 14 HUNTERS GATE COURT, SILVER APRING, MD 20904-1826 Health Pm 27 I item 27 20e. Method of Disposition 20b. Plece of Disposition (Neme of cametery, cramatory or other plece) 20c. Location - City or Town, Stete 1 XBurial 2 ☐ Cremation 3 ☐ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) permit. Page Department of Important: If eny injury or = 0 SAVAGE METHODIST CEM. 8/12/98 MT. SAVAGE, MD 21. Signature of Funerel Sewice licensee 22. Name end Address of Fecility SOWERS FUNERAL HOME, P.A. 23a. Part1. Enter the disease, or complications that different the deeth. Do not enter the mode of dying, such as cardiac or respiratory errast, shock, or heart feiture. List only one ceuse on each line. Approximete Intarvel Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition rasulting in death) 2 Mun Examiner Examiner Lecurent 144 physician and the burial-transit that the death certificate be axecuted Sequentietly list conditions, if eny, leeding to immediate causa. Entar Undarlying Cause (Disease or Injury that initiated events resulting in daeth) Lest Due to (or es e consequence of) Hyperlands
Due to (deas e consequence of): P.O. Box 68760. Physician/Medical 980 for signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause givan in Pert I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown Records, þ The law requires 24b. Were eutopsy findings eveilable prior to been significant 24a. Wes en eutopsy performed? Completed completion of cause of death? cartificate has b lirector, page 2 s 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Attending Physician: 25. Was casa raferred to medical examiner?
1 ☐ Yas 2 No director Be 26. Placa of Daeth (Check only ona) Hospitat: Other: 4 Nursing Homa 5 Residenca 6 Other (Specify) Inpatient 2 2 ER/Outpatiant 3 DOA this. funeral 27. Mannar of Daath 28a. Dete of Injury (Month, Dev Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: Aftar 5 Panding Invastigation 1 Naturel 1 ☐ Yas 2 ☐ No death. 2 Accidant rector: A 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 - Homicide hin 24 hours after the Funeral Dire mpletaly filled in b 6 29a. Cartifian edicai Certifying Phyeiclan: To the best of my knowledge, deeth occurred et the time, date and placa, and due to the ceusa(s) and mannar es steted. (Check only one) 2 Madical Examiner: On the basis of examination end/or investigetion, in my opinion, death occurred et the time, dete and place, end due to the ceuse(s) and menner stated. within 2 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dev. Yeer) copie mo D-13166 AUGUST 30. Nema end eddress of person who completed eause of deeth (Item 23e) (Type, Print) rosing, sann 12 wace

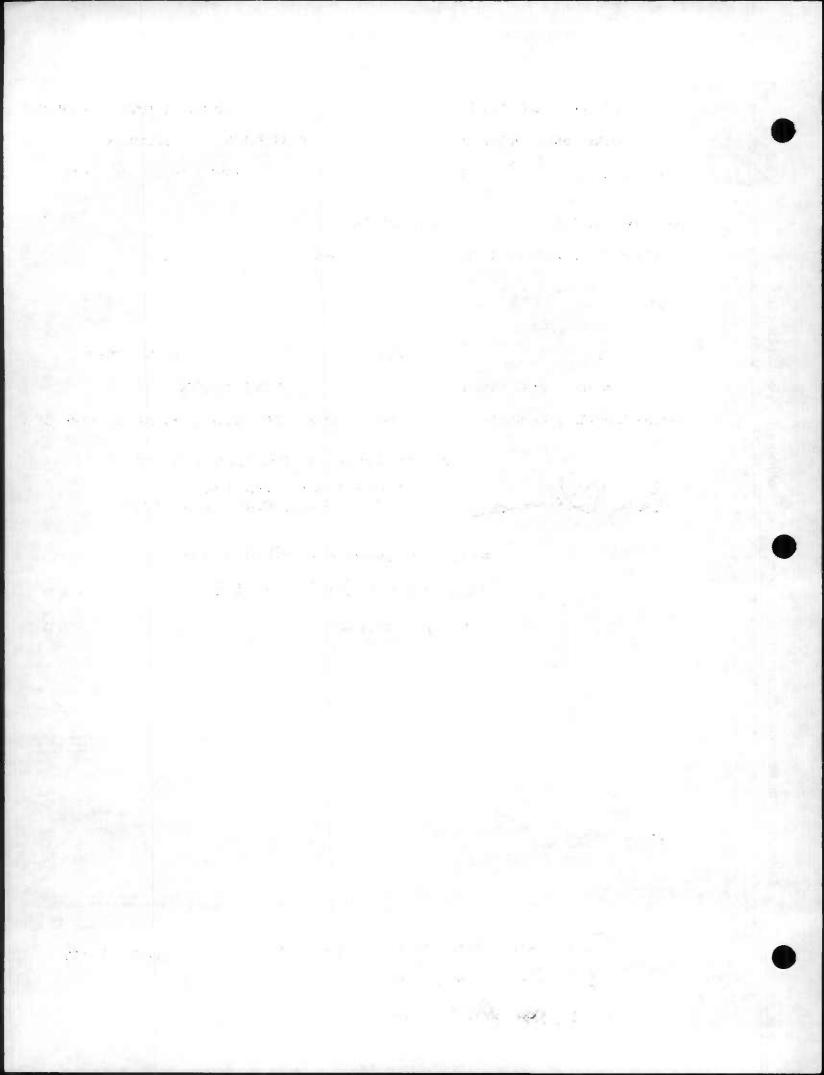
32. Registrer's Signature

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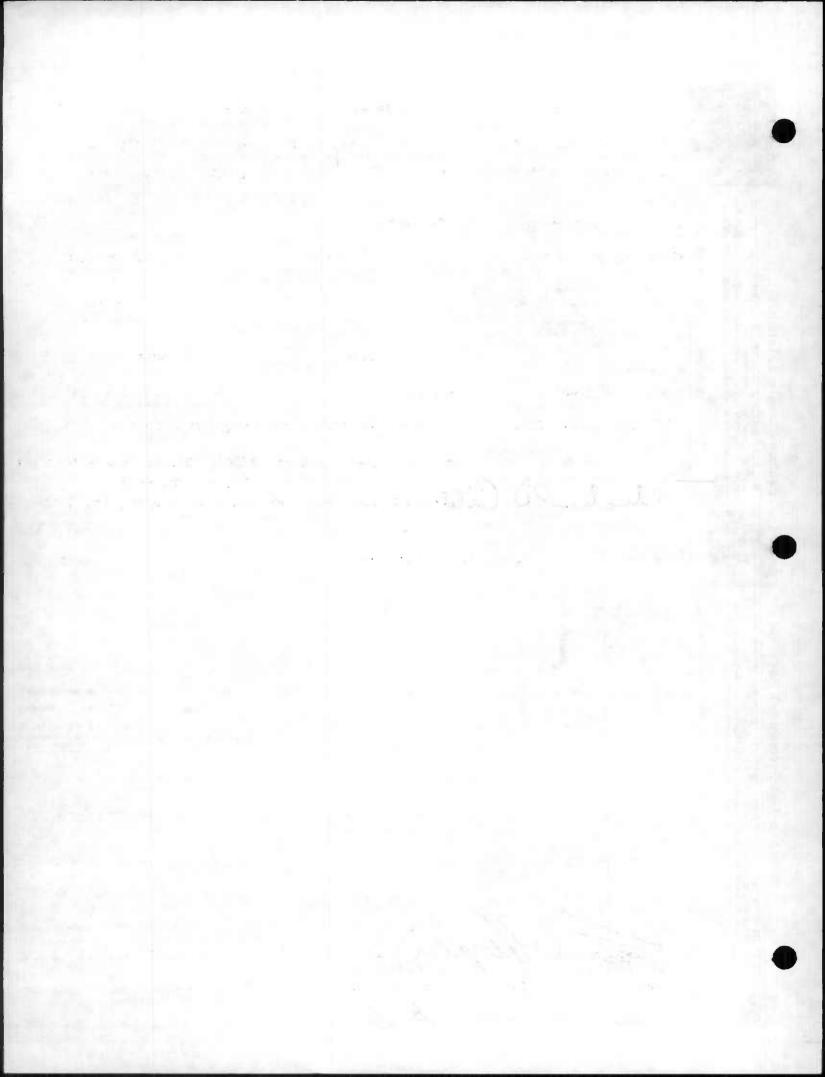
31. Dete filed (Month, Dey, Year)

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State of Maryland / Department of Health and Mental Hygiene

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dical		Ultimo			DiSessa		August		98 7:16 A
niner	4e Fecility I	leme (If not Institution, g	give street end number)			4b. City, Town, or L	ocation of Death	4c. County of	f Deeth
	1956	O Frederick	Road			Germanto	own	Mont	gomery
1			. Sex 7. Ag	ge (In yrs. last bii	thday) If Under 1 Year Months Days	If Under 24 Hrs.	8. Dete of Birth (Month, Day,		Birthplece (State or Fo Country)
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	10e. Stete	10b. County		10c. City, Tow	n or Location				10d. Inside City L
Director	Maryla		mery	Germ	antown				
Sire	10e. Street	nd Number			10f. Zip Code		1	0g. Citizen of Wh	net Country?
Funeral	20549	Neerwinder	Road		208	74		United	States
5	11. Maritel S	tatus	12. Was Decedent Armed Forces?	Ever in U,S.	13. Was Decedent of I	Hispenic Origin? (Spean, Mexican, Puerto	ecify Yes or No- Rican, etc.)		- American Indien, White, etc.
Dy L		er Married 213 Married			1 ☐ Yas 2 ☑ No			Specify:	
	3 D Wid	owed 4 Divorced	Yeer or Dates:			,		ороспу.	White
-		15. Decedent's (Specify only highest)	Education grade completed)	16e	Decedent's Usuel Occu (Give kind of work done	during most of world	ing	16b. Kind of Busi	Iness/Industry
Completed	Elamanta	ry/Secondary (0-12)	Collaga (1-4or	5+)	lifa. DO NOT use ratire	ed)			
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2	7 / 1	Costabi	.le	DiSess	sa		Adelina	3	Salzano
	19a. Inform	ant's Name/Relationship	(Type, Print)	196	. Mailing Address (Stree	t and Number or Ru	ral Routa Number	, City or Town, S	tate, Zip Code)
	Este	lla DiSessa	/Wife)549 Neerwin	nder Rd.,	Germanto	vn, Mary	land 20874
		of Disposition	Domewal from State	comete	f Disposition (Name of ry, crematory or other pla	ice)	Date	20c. Location - C	City or Town, Steta
		iel 2 ☐ Cremation 3 netion 5 ☐ Other (Spe			f Heaven Ce	metery 8	3/24/98	Silver S	pring, Maryl
_	21 Signetu	e of Funeral Service Lic	ensee N		22. Name end Addr	nes of Facility	Vol Fun		
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-	23a Pert1	Enter the disease or or	molications that cause	d the death Do	◆IU East De not anter the mode of dy	er Park D	r., Gait	hersburg	g, MD. 2087
	shock	or heart fallure. List on	ly one ceuse on each li	ine.	not anter tha mode of dy				Intervel Betwee Onset end Dee
	Immediate	Ceuse (Final							
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ē				Due to (or es e	consequence of):				
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edicai	resulting in	Jaath) Last		Due to (or es e	consequenca of):				1
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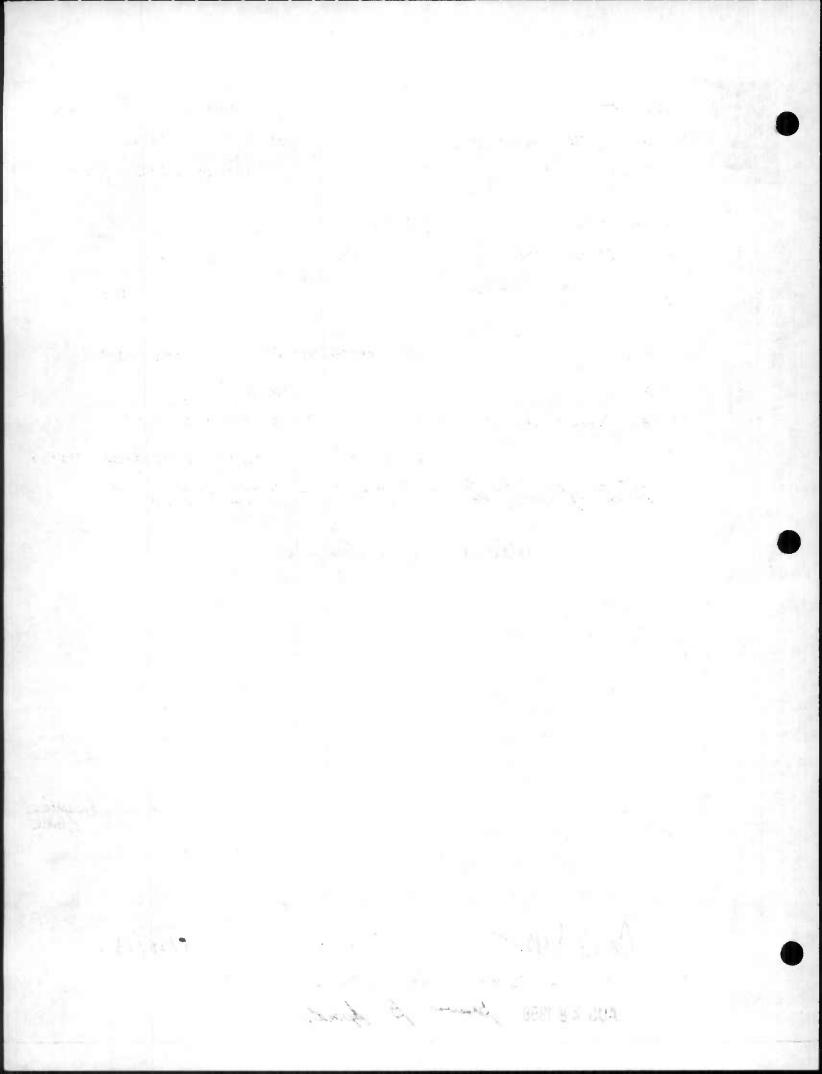


	-11	Decedent's Neme (First, Midd	fle (ast)		Cer	tificate	9 OI L	<i>Jeain</i>	2 Date	Re of Deeth	g. No.	1	Time of Deeth
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edic min	- 10	4e. Fecility Neme (If not institution	on, give street en	d number)			41	c. City, Town	, or Locetion of	-	4c. County	of Deeth	10/
	•	Union Hospita	1					Elkto	on		Ceci	1	
ral or		5. Social Security Number 193-36-2156	6. Sex 1 [™] M 2□	7. Age (In yrs	. last birthday) Yrs.	if Under	1 Year Days	If Under 24 Hours	Min. (Mon	th, Dey,	Yeer) 1949	9. Birthplace Country) Pennsy	(Stete or Foreign
		Usuel Residence of Decedent							oury	٠,	1343	r cimby.	LVania
		10a. Stete 10b. County	у	10c. C	ity, Town or Lo	cation							nside City Limits
	Director	Pennsylvania	Lehigh	E	aston								Yes 2□No
1		10e. Street end Number				10f. Zip				10		Whet Country?	
	Funeral	4066 Winfield 11. Marital Status		Decedent Ever in I	I.S. 13 V			nenic Origin	? (Specify Yes	or No-		d State	
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ouce.		21. Sign ture of Funeral Service	Licansee		22 H i	. Name end	Address	of Fecility	unerals			nsylvan	.да
		Donned	. S. Hi	Call								laryland	21921
r	ler	disease or condition resulting in death)	e. 17	SCV Due to		200						y	ars
1	Medical Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Last	6. V.		1 1		rill	atic	m			1	hour
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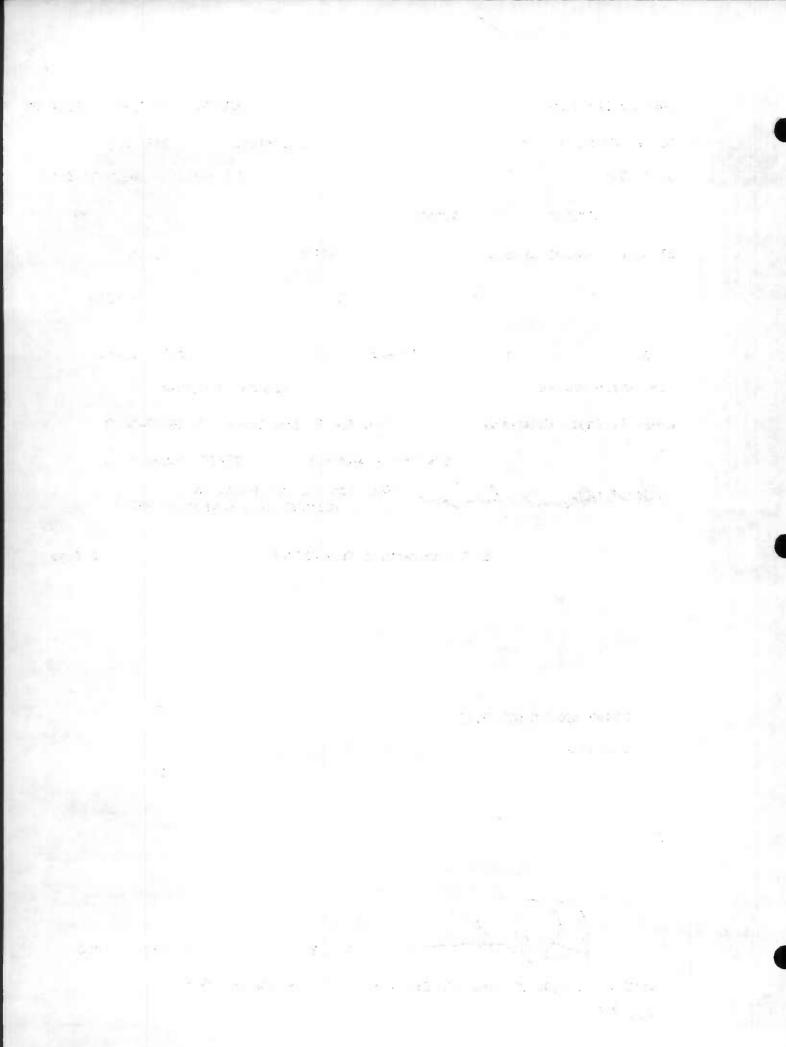
State of Maryland / Department of Health and Mental Hygiene 0

-910	-	1. Decedant's Nama (First, Middia, i	(ant)					100110						
Physici	ian		Lest/					2. Data of D	Day	Year	3. Time of Dec			
/Medi	cal	Stephan Demchyk							August 26, 1998		7:20a.m.			
Examir	ner	4a. Facility Nama (If not institution, g						or Location of Dea		ity of Death				
		Hospice House, 586				811-1-4	Easton			1bot				
Funeral Director		5. Social Sacurity Number 6. 214-32-2312 Usual Rasidanca of Decedant	. Sax 1X M 2□ F	iga (In yrs.	73 Yrs.	If Under 1 Y Months D		in. Januar	y 1, 192	9. Birthp Coun 25/UKY	laca (Stata or Fo itry). Taine			
28a-f show	_	10a. Stata 10b. County		10c. Ci	ty, Town or Loc	cation				1	0d. Insida City L			
18	cto	Maryland Kent		Che	esterto	wn					1 🗆 Yas 2			
20	Dire	10a. Straat and Number				10f. Zip Co			10g. Citizan of What Country?		itry?			
23	<u>a</u>	22677 Handy Poin	t Road			216	20		U.S.	.A.				
urs e	by Funeral Director	11. Marital Status 1 □ Navar Marriad 2 □ Married 3 ※ Widowed 4 □ Divorced	12. Was Dacedan Armed Forcas 1 ☐ Yas 2 X if Yes, Giva Yaar or Datas:	? No		Vas Dacedant Yas, specify □ Yas 2	t of Hispanic Origin? Cuban, Maxican, Pu No Spacify:	(Specify Yas or Narto Rican, atc.)		ace - Amaric lack, Whita, i lify: Whi	atc.			
natu lical	tec	15. Decedant's (Spacify only highast of	Education	ication la complatad)		16e. Decedant's Usual Occupation (Giva kind of work dona during most of lifa. DO NOT usa ratired)			16b. Kind of I	b. Kind of Businass/Industry				
	Completed	Elementery/Secondary (0-12)	College (1-4or	5+)	Soil Conservat		atired)	d) most of working						
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	Be	17. Father's Nama (First, Middla, Las	st)				18. Mothar's N	lama (First, Middl						
	To	Unknown					Unkno	own						
th end Mer 7 Is marke traumatic		19a. Informant's Name/Raiationship	(Type, Print)		19b. Mailing	g Addrass (St	traet and Number or		ber, City or Town	n, Stete, Zip	Coda)			
Heelth e em 27 la other tra		Stephanie Lacaze	/Daughter		532 S	. Auro	ra Street	, Easton	, MD 21	1601				
		20a. Mathod of Disposition		20b. F	Piace of Dispos camatary, cram			Data	20c. Location	- City or To	wn, Stata			
6 = 5		12 Buriai 2 □ Cramation 3 4 □ Donation 5 □ Other (Spec	oify)	2 1 .	ester C	emeter	У	August 30	, 1998/Ch	esterto	wn, Maryl			
Departmen Important any Injury once.		1 1/10/	0/1/	21. Signatura of Funaral Service Licensee 22. Nama and Address of Facility Fell Jours Holfenhain & Name Burgeral Home P A										
	$\overline{}$	23a. Part1. Entar tha disaasa, or complications that causad tha death. Do not antar the mode of dying, such as cardiac or raspiratory arrast, Approximately a such as cardiac or raspiratory arrast, Interval Interva												
		23a. Part 1. Entar tha disaasa, or con	mplications that cause	d tha daat	h. Do not anta	Speer of the mode of	Road, Chester dying, such as card	ertown, Ma	ryland 216 arrast,	620	Approximata			
hysician		23a. Part 1. Entar tha disaasa, or con shock, or haart failura. List onl						ertown, Mailiac or raspiratory	ryland 216 arrast,	620	Intarval Batween			
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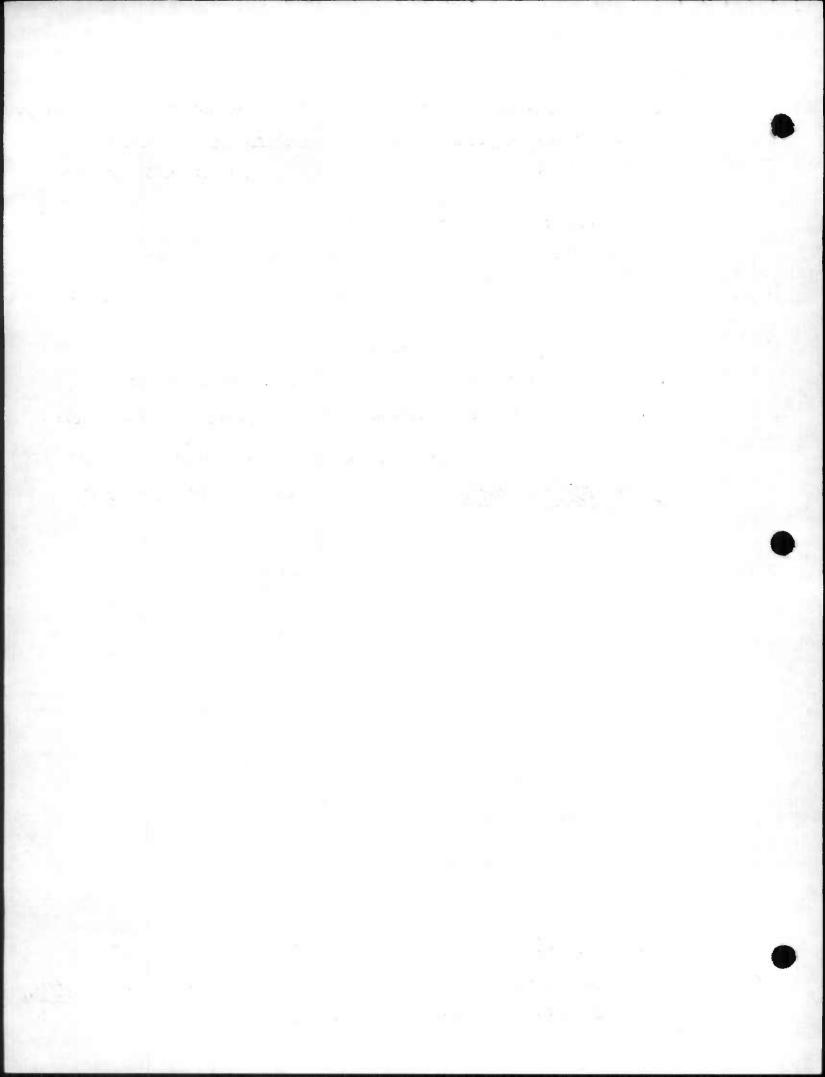


State of Maryland / Department of Health and Mental Hygiene

Physician /Medical Examiner	Barbara								2. Data of Das			3. Tima of Death
/Medical		I DO HTO	1. Decedant's Nama (First, Middla, Last)						Month	Day	Yaar	
Examiner	As Essilibutions (If not institution, give street and number)								AUGUST			2338 PM
				oer)				4b. City, Town, or Lo	ocation of Death			
5	Sacred Heart Hospital Cumberland Allegan 5. Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) If Undar 1 Yaar If Undar 24 Hrs. 8. Data of Birth 9. Bir											
Funeral Director	233-46-9	233–46–9464 Usual Rasidanca of Dacedant					s Days		8. Data of Birti (Month, Day 07/01/	Day, Year) Country)		
yend	10a. Stata	10b. County		10c. C	ty, Town	or Location					1	0d. Insida City Limits
Man Help	WV	MINERAL	_	KE	YSER							XXYas 2 No
sa or 28a-fe at be notified	10e. Street and Nut		L Street			10f. 2	Zip Coda 26	5726		10g. Citizen of V		try?
filed within 72 hours after death with the Marylend Hygiene. Hygiene. Hygiene ther than "natural", or items 23s or 28s-f show ent, the Medical Examiner must be notified at Completed by Funeral Director	3 ☐ Widowed	ad 210 Married	12. Was Daced Armed Forc 1 Yas 2 If Yas, Giva Yaar or Date	as?	J,S.		cedant of becify Cut	Hispanic Orlgin? (Spoan, Maxican, Puarto	ecity Yas or No- Rican, atc.)	Blac	e - Amaric k, Whita, Whita	atc.
2 should be filed within 72 hours end Mantal Hygiene. I marked other than "natural", surmatic event, the Medical East aumatic event, To Be Completed by	(Spec	15. Decedent's E		ucation 16a. D. da complated) ((Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired)			16b. Kind of Businass/Industry		dustry
not and	Elamantary/Seco		College (1-4	ior 5+)								
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00			Ramoval from St	ata	cematary	Disposition (for crematory of the Cove Cove Cove Cove Cove Cove Cove Cov	r othar pla		Data 3/27/98	Morgan		wn, Stata
parmit. Pag Depertment Important: I any injury o	21. Signature of Fu			4		Maria	hoor	ass of Facility	Iomo In	_		
	ferre	CASECE	whole	ing	~	111	S. M:	ineral St.	, Keyse	r,WV 26	726	Approximata
Physician /Medical Examiner	Immadiata Causa disaasa or condition resulting in death)	Final		CUTE	MYOCA		INFA	ARCTION				Intarval Batween Onset and Daath 2 days
D # C												
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bed by		VEKE AURI	TIC STENC	DSTS					-			
been shoul		PHYSEMA								an autopsy rmed?	av	ara autopsy findings ailabla prior to mplation of causa death?
certificate has rector, page 2									101	as 2 No	1[Yas 2□No
or, p	25. Was casa rafar	rad to medical	1					26. Place of Daai				
ysician: is certific director,	axaminar?		Hospital:	patiant 2] EB/Out	natient 3	DOA O	thar:	oma 5 Rasio		ar (Spacil	iv)
E E E	27. Manner of Deat 1 XNatural 2 Accidant		28a. Data of (Month,		28b. Ti		28c. Inju		28d. Dascribe h			
To the Hospital or Attending P within 24 hours stare death. To the Funeral Director: After completely filled in by the funeral Medical Certification:	3 Suicida 4 Homicida	6 Could not be datarmined	28e. Place o							Street and Number or Rural Routa Number, vn, Stata)		
To the Hospital or within 24 hours after To the Funeral Dir completely filled in Medical Cert	29a. Cartifiar (Check only one)	1 Cartifying P	hyaician: To tha b	is of axamin	owledge, ation and	death occurr or investigati	ad at tha toon, in my	ima, date and place, opinion, death occur	and dua to tha red at the time,	causa(s) and made and place,	annar as s and dua to	tated. the cause(s)
ithin ithin on the omple		titla of conting	1.1	//			29c. Licar	sa number		29d. Data signe	d (Month,	Day, Year)
8	•	R	Strut	4			D26			29d. Data signed (Month, Day, Year) AUGUST 25 1998		
-	30. Name and addr	ass of person who	complated causa	of death (Ite	m 23a) (1	Typa, Print)						
/ 40 . D									015			
mis	RICHA	RD G. SC	HMITT M.	D. 900	SET	ON DRI	VE C	UMBERLAND	MD 215	002		

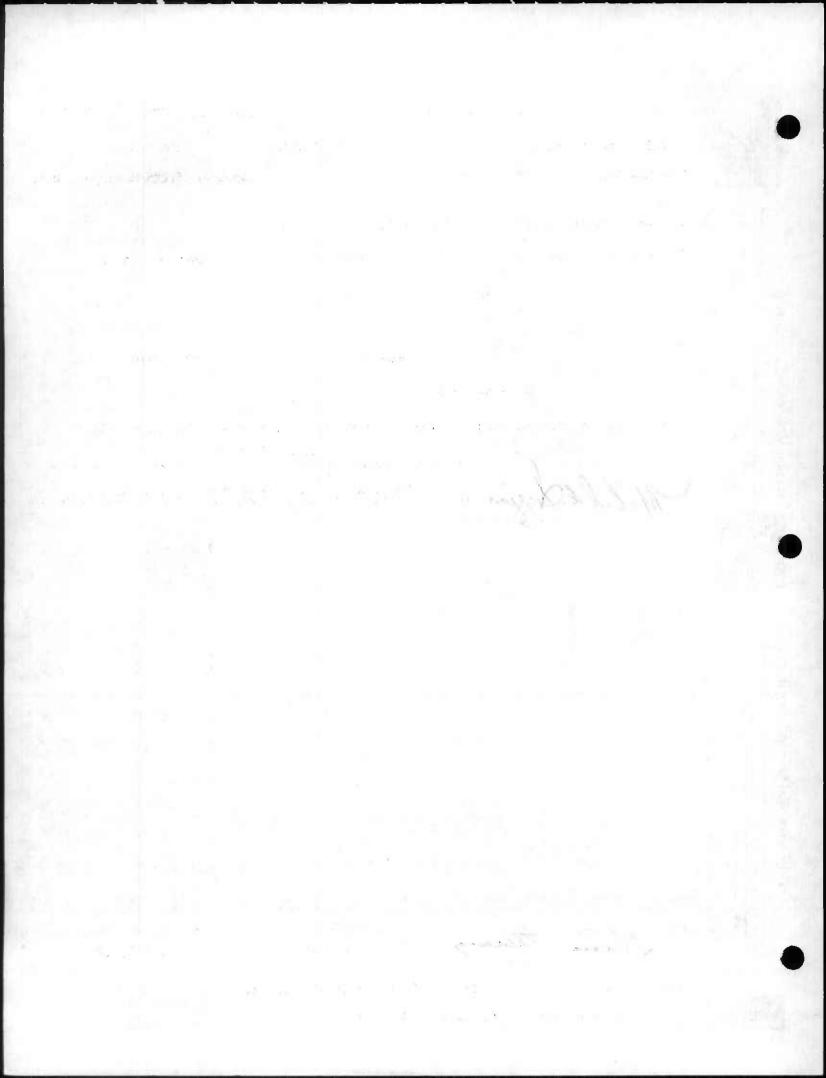


				of Marylar				Death			Re	g. No.	2	137	5
Physici /Medio		Decedent's Name (First, Middla, Last John Wi.) lliam	Ed	elen					2. Date of Month	1	Dey	Year 1998	3. Time o	of Death : 10 pi
Examir		4a. Facility Name (If not Institution, giva	street end nu	mber)			4	b. City, To	wn, or Lo			4c. County			
	, N	Calvert Count 5. Sociel Security Number 6. Se		rsing 7. Age (In yrs.			r 1 Yeer	Prince				Cal	vert	(O+ 4)	
uneral irector			M 2□F	72	Yrs.	Months		Hours	Min.	8. Date (Mont) Dec.	11,	1925	Vash	ace (Stata	or Foreign
***		Usuel Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or L	ocation	1						10	Od. Inside C	City Limits
rad a	tor	MD Calvert		Pri	ince F	reder	ick								2 No
or 28	Director	10e. Street and Number					p Code				10	g. Citizen of \	Whet Count	try?	
m 23a	eral	85 Hospital Road	12 Was Dog	edent Ever in U	C 12		678	ionania Orie	ning (Car	oih: Van	w No	USA	e - America	n Indian	
r than "natural", or frams 23a or 28a-f show the Medical Examiner must be notified at	by Funeral	11. Meritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Fo 1 12 Yes It Yes, Gir Year or D	orces? 2 No ve 1944	4–46	tt Yes, spe	cify Cuba	ispenic Origin, Mexican Specify:	, Puerto	Rican, etc	or No- :.)		k, White, e		
dicel	eted	15. Decedent's Edu (Specify only highast grad			16a. Dece	edent's Usu	al Occup	ation during most	of work	'na	10	6b. Kind of B	usiness/Ind	ustry	
than the Ma	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work dona during most of life. DO NOT usa ratired) Installer						Utilities				
d othe event,	event, Be C	17. Fether's Name (First, Middle, Last) Bernard Reginal	elen	18. Mother's Na Nellie					ame (First, Middla, Maidan Suma Blanche Light			_{ama)} tfoot			
2 5	_	19a, Intorment's Name/Relationship (7) Bernard Matthew I	pe Print) Edelen/	'son	3406	ing Addres Hill	s (Streat Side	and Numbe Place	e C	n Route N	oeak	City or Town, e Beac	State, Zip h, MD	Code) 2073	32
Important: If Item 27 any Injury or other tr once.		20e. Method of Disposition 1 XBurial 2 Cremetion 3 F 4 Donation 5 Other (Specify)	Removal from	State	Placa of Disponentary, cre	metory or	othar pled	*	1	Dete		0c. Location -	7.5		, MD
importar any inju		21. Signature of Fungral-Blavice Livens	35	22. Name and Address of Facility Rausch Funeral Home, Owings, MD								736			
		23a. Pert1. Enter the disease, or comp shock, or heart failure. List only o	Icetions that t	ardsed the deet	h. Do not en							- '		Approxime Interval Be	ite
sician edical miner		Immediate Cause (Finel disease or condition resulting in death)		PAGUN	LONIA	t								Onset and	Death
	Jer	and the second second		Due to (d	or es a conse	quence of)	*						1		
the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	Due to (c	or as a conse	quence of)	:								
	Medical	Cause (Disease or injury that initiated events resulting in death) Lest	Due to (or es e consequenca of):												
attending for use as	Physician/M		3.												
by me	hysi	Part II. Other significant conditions con			uiting In the u	anderlying	cause giv	en In Perti. I		23b.		e 2 No		the cause ably 4	
8	þ	SEVERE ALZ		-	UZS	pho	tolo			248.	Was an	autopsy	24b. We	re autopsy	findings
ate has been s page 2 should	Completed	HYPOTHYROID		MEN 1	PUL	MON	HCY	MAS	-		perform	ed?	con of d	ilable prior noletion of leath?	cause
	Be Cc	25. Was case reterred to medical	, (prone	1169 6	ARTEI	ry o	26. Place	ot Death		1 Yes		11.	Yes 2	No
this certific ral director,	P	1 105 20 NO		-	ER/Outpatie			44EI NUI				nca 6 🗆 Oth)	
After	ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date (Mon	of Injury th, Dey Year)	28b. Time of injury	M	28c. tnjun Wor 1 🗌	/at k? Yes 2∐h		28d. Desc	ribe hov	v Injury occur	red		
5 ≥	Certification:	3 Sulcide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28t. Location (Street and N City or Town, State)									er or Rurai	Routa Nur	nber,		
To the Funeral Dire completely filled in b	edicai	29a. Certifier 1 Certifying Physical Check only one) 1 Medical Exami	ner: On the ba												s)
To the comple	Me	29b. Signature and title of certifier	, ,			29	c. Licens	number	-		290	d. Dete signe	d (Month, L	Day, Yaar)	
I VA		presp. 1	ufac				DS	0763	5						
		50. Name and address of person who co	mpleted caus	e ot deeth (Item	1 23e) (Type,	Print)	RE	Leve	D.	CULTZ	109	RAR	FD45P	icle i	40
Sta	te	31. Date tiled (Month, Day, Year)	32. R	egistrara Signa		1	1701	- Fere	1	30110	,0/,	KIKO	.,, 0,0	2	.0678



State of Maryland / Department of Health and Mental Hygiene ()

		1. Decedent's Neme (First, Middle	, Last)			tificate c		2. Dete of D	_		me of Deeth					
ysicia	-		Lvda	M. Ec	kho1m			August	23, 199	Yeer 2	:05 AM					
/ledica amine	-										MA CU.					
u	"	705 Woodburn	Road				Rockvil									
eral	7			Age (In yrs.	last birthday)	If Under 1 Ye	ar If Under 24 Hrs	s. 8. Date of B	irth		tate or Foreir					
ctor	-	578-30-5090 Usuel Residence of Decedent	1□ M 2X F	71	Yrs.	Months De	ys Hours Min	. (Month, D	lev. Year)	9. Birthplace (S Country) Washingto	n, D.C					
10		10a. State 10b. County		10c. City	, Town or Loc	cation				10d. insi	de City Limit					
notified at	ō	Maryland Monte	gomery	mery Rockville							Yes 2□N					
Det.	9	10e. Street end Number	50.1102 /	10f. Zip Code						Whet Country?						
<u> </u>	5	705 Woodburn Road 20851							United							
Count	era	11. Marital Stetus	12. Was Decede	nt Ever in U.	S 13 W			Specify Ves or N		ce - American India	20					
Important: If item 27 is marked other than "natural", or items 23a or 28a-fs any injury or other traumatic avent, the Magical Examiner must be norther once. To Be Completed by Funeral Director		1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Force	s? ∑iNo	If	Yes, specify C ☐ Yes 2 1 N	of Hispenic Origin? (uban, Mexicen, Pue lo <i>Specify:</i>	to Rican, etc.)	Ble Specif	ck, White, etc.	x(1)					
	8	15. Decedent's	s Education	cation		ent's Usuel Occ	cupetion		16h Kind of B	usingss/Industry						
	Die	(Specify only highest	grede completed)		(Give I life. D	kind of work do	cupetion ne during most of wo ired)	orking	16b. Kind of Business/Industry							
100	E	Elementary/Secondery (0-12)	College (1-4d	or 5+)	Homemaker				Own Ho	me						
ent,	0	17. Fether's Neme (First, Middle, L.	ast)		110111	omare I	18. Mother's Na	me (First, Middle	e, Maiden Sumen							
2 0	10 0	77 1 77 14						a O. Gil								
E P	-									State Zin Code)						
Š		Gregory J. Eckh		d												
	-	20e. Method of Disposition	iorm, ilusbai	20b. P	ece of Dispos	sition (Neme of	Road, Ro	CKV111e,		nd 2085 - City or Town, Ste						
6		1 X Buriel 2 ☐ Cremetion		te	20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) August 26 Parklawn Memorial Park			6, 1998								
dan	-	4 Donetion 5 Other (Spe		klawn	Memoria	Rockville, Maryla			land							
once.		21. Signature of Funeral Sen & Licens Modern A. Pumphrey Fune MO0846 300 West Montgomery Ave							Rockville, M	e, Inc. aryland 20	850–28					
ian cal ner		Immediate Cause (Final disease or condition resulting in death)	e. Cancer			uence of):			•	3 Moi	nths					
		Due to (or es e consequence of): Extensive Metastatic Disease														
s ina bunal-transit	Cyalline	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury thet initieted events	Ь.		to (or as e consequence of):											
		Cause (Diseese or Injury	C	cDue to (or es e consequence of):												
es ma bu	2	resulting in deeth) Lest														
0	E		d													
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be detected for usa								1	Yes 2N No	3 Probably	4 □ Unkno					
Silouis Pata													24e. Wes	s en eutopsy ormed?	24b. Were euto evaileble p completion of deeth?	rior to
nas ceen ja 2 shoul	5							10	Yes 2 No	1 ☐ Yes	2 No					
7 6)	25. Wes cese referred to medical					26 Plans of Do	eth (Check only		1 1 1 4 5	2L 140					
CO G) [exeminer? 1 ☐ Yes 2 ☒ No	Hospital:	tiont OF	D/Out-ations	2D 2004	N. I.									
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To Be	•	27. Menner of Deeth	(Month I	Day Year)	Injury	28c. In W	ork? □Yes 2□No		7-7 0000							
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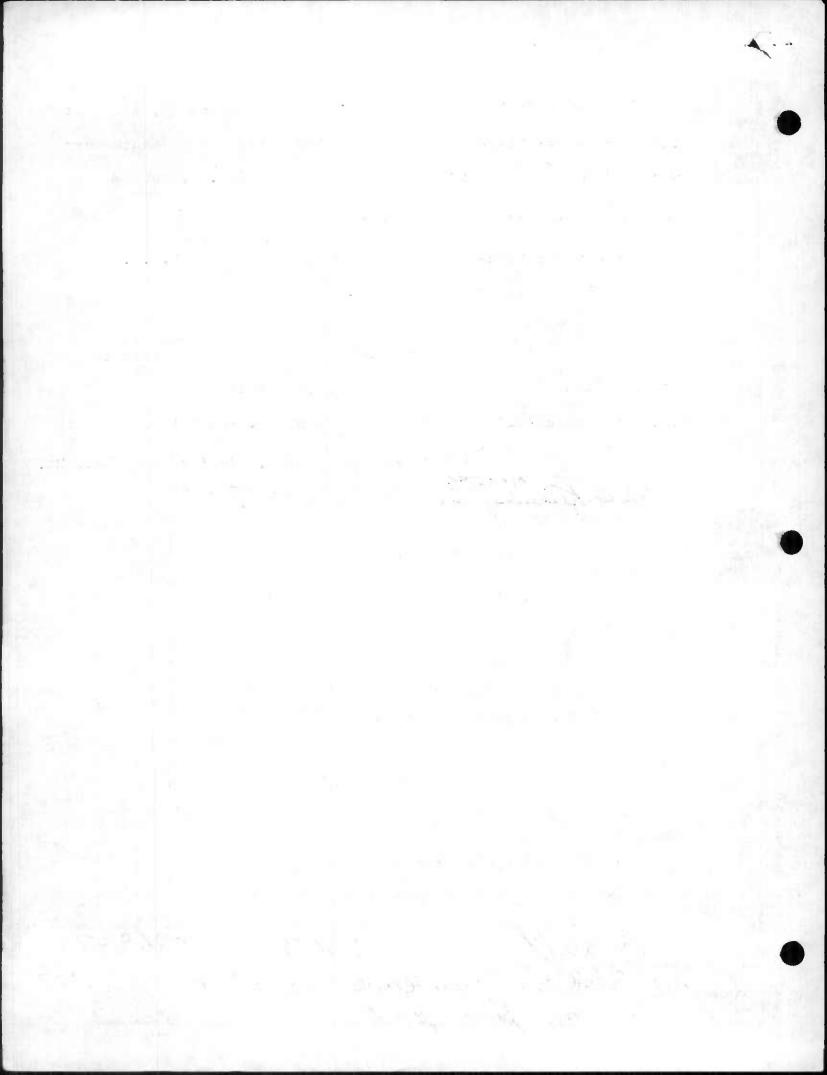
State of Maryland / Department of Health and Mental Hygiene

			State of Mi	ai yiai iu /		ificate o	f Death		Reg. No.	2/3//			
Dhuaiai		1. Decedent's Name (First, Middle, La						2. Dete of De	eth Dey	3. Time of Deeth			
Physici /Medio		Melville	Ehrlich					Augus		1998 11:20pm			
Examir	er	4a. Fecility Neme (If not institution, giv	e street and number)				4b. City, Town, or Location of Deeth 4c. County of Deeth						
		10401 Grosven				80 1 11	Rockvil			ntgomery			
Funeral Director		080-05-0074	ex 7. Ag	e (In yrs. last bi	Yrs.	Months Dey		8. Date of Bir (Month, De	by, Year) 6,1904	Birthplece (State or Foreign Country) MA			
pud *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	un or Loos	ation							
Maryle f sho	10	Maryland Mont	gomerv		kvi1					10d. inside City Limits 1 ☐ Yes 2 ☐ No			
1 the	Director	10e. Street end Number				10f. Zip Code			10g. Citizen of V	Vhet Country?			
h with	al D	10401 Grosven	or Place			20	852		U.S.	Δ			
deat	Funeral	11. Maritel Status	12. Wes Decadent Armed Forces?	Ever in U,S.	13. Wa		Hispenic Origin? (Spuben, Mexican, Puerto	pecify Yes or No		e - American Indien, k, White, etc.			
and 2 should be filed within 72 hours after death with the Maryland alth and Mental Hygiena. 7.27 is marked other than "netural", or flems 23a or 28a-f show for traumatic event, it a macrael Examiner man to not hed.	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 If Yes, Give Yeer or Dates:			Yes 2√2 N		Triodit, oto.,	Specify				
72 hc	eted	15. Decedent's Ed (Specify only highest gre	lucation de completed)	169	Deceder	nt's Usuel Occ	upetion	kina	16b. Kind of Bu	siness/industry			
vithin na. han	Completed	Elementary/Secondary (0-12)	College (1-4or 5				e during most of work red)	g	te				
Hygie Hygie ther ti	Co	17. Fether's Neme (First, Middle, Last)	5+	A	ttoı	rney	18. Mother's Nam	o /First Middle		ctice			
d be i	Be c	Avram Ehrlich					Ida Ro			6)			
shoul nd Me mark	To	19e. Informent's Neme/Reletionship (Type, Print)	198	b. Meilina	Address (Stre	et end Number or Ru			State, Zin Code)			
nd 2 alth alth ar 27 is		Beatrice Ehrli								MD 20852			
permit. Pages 1 and 2 should be filed within 72 hours Depertment of Health and Mental Hygiena. Important: if Item 27 is marked other than "netural", any injury or other traumatic event, if a Health and Injury.		20e. Method of Disposition		20b. Plece o	of Disposit	tion (Neme of		Dete		City or Town, Stete			
Page nent c int: If		15 Buriel 2 Cremetion 3 Remove from State 4 Donetion 5 Other (Specify) Parklawn-Menorah Gdns. 8/20/98 Rockville, MD.											
permit. Depentral Importal any inju		21. Signeture of Funeral Service Licensee Moosite. 122. Name end Address of Fecility I ves-Pearson Funeral Home											
8 5 E 5 8		1 Wa a Kee	Derla A	will	1 V	res-Pe 347 Wi	arson Fu Ison Blv	neral	Home	, VA 22201			
		23a. Pert1. Enter the disease, or com- shock, or heart failure. List only	olicetions thet caused	I the deeth. Do	not enter	the mode of d	ying, such es cardiec	or respiretory e	rrest,	Approximete Intervei Between			
Physician										Onset end Deeth			
/Medical Examiner		Immediete Ceuse (Final diseese or condition resulting in death)	. Cong	105/	100	1/0	ort to	Bilur	e				
147	-e			Due to (or es e	conseque	ence of):	ert Fo						
uted	Examiner		b. Coro	nary	1	1401	y VISE	236					
exect In and rial-tra	Exa	Sequentially list conditions, if eny, leeding to immediate cause. Enter Undertying Ceuse (Disease or Injury c.											
icata be executed physician and s the burial-transit	edical	Ceuse (Diseese or Injury thet Initiated events Due to (or es e consequenca of):											
E 000		resulting in deeth) Lest								İ			
ettanding for use ex	an	_	d							1			
the e	ysic	Pert II. Other significant conditions of	ontributing to deeth bu	ut not resulting i	n the und	erlying cause g	given in Pert I.	23b. Did	tobacco use cor	tributa to the cause of death?			
requiras that tha death certificata be executed been signed by the ettanding physician and should be detached for use es the burial-transi	Completed by Physician/N	Chronic Obst.	active	2 Lua	100	Dise	252	1 🗆	Yes 2 No	3 Probably 4 Unknown			
uiras Isign	Q P			_				24e Wes	an autopsy	24b. Were autopsy findings			
v req	lete							perfo	ormed?	eveilable prior to completion of cause of deeth?			
The law ate has b	E							10	Yes 2000No				
iclan: The certificate rector, peg	Be C	25. Wes case referred to medical					26. Plece of Deel		(-	1 ☐ Yes 2 OYNo			
Physician: rthis certifica	To B	exeminer? 1 Ves 2 No	Hospitel: 1 Inpatie	nt 2 ER/Ou	utpatient	3D DOA	ther: 4 Nursing Ho		dence 6 Oth	er (Specify)			
ar thi		27. Menner of Death	28e. Date of Injui	y 28b.	Time of	28c. Inj W			how injury occurr				
ath. vr: Aft	atio	1 Neturel 5 Pending Investigation		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	injury		Yes 2 No						
or Attending Physician: thar death. Director: Aftar this certific in by tha funeral director,	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Plece of Injubuilding, etc	ury - At home, fe c. (Specify)	erm, stree	t, fectory, office	ə	28f. Location (: City or To		er or Rurel Route Number,			
pitai ours a ers! (29a. Certifier 1 Cartifying Ph	valcian: To the best of	of my knowledge	a death o	onured at the	time data and class	and due to the	(a) and ma				
To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After complately filled in by the funer	edicai	(Check only 2 Madical Examone)	iner: On the basis of end menner ste	examinetion en	d/or Inves	stigetion, in my	opinion, deeth occur	red et the time,	dete end plece,	end due to the cause(s)			
To t To t	Σ	29b. Signeture and title of certifier	1//			1	nse number		29d. Dete signed	(Month, Dey, Yeer)			
15		1 della	1			D 3	36797		08/	17/98			
	-	30. Name end eddress of person who	completed cause of de	eeth (Item 23a)	(Type, Pr	int)	2/0	11	1	1 01-			
		31. Dete filed (Month, Dey, Year)	41)	0251			Rd, B	othes	15 W	D 2081			
Sta Registra		AUG 2.5 1998	A	er's Signeture	4	how V							
J		HUU 6 0 1338	Angel		1	0000 K							

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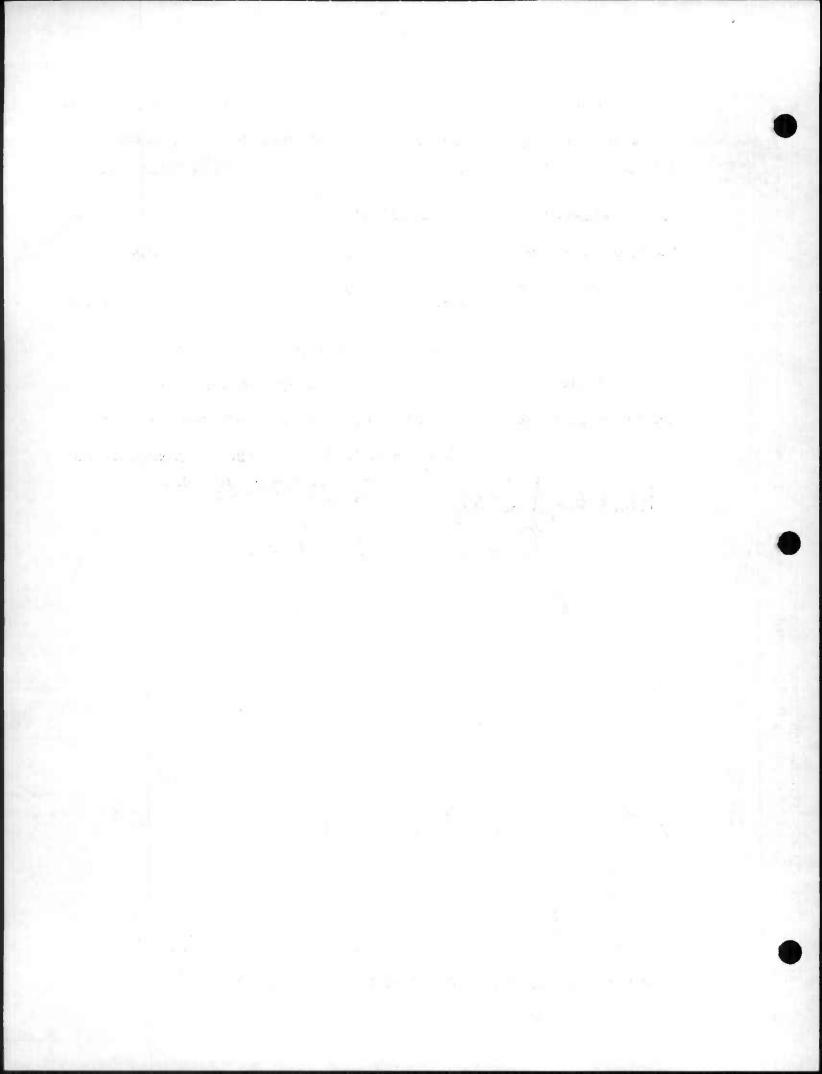
JW ■ Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



State of Maryland / Department of Health and Mental Hygiene Q

	_				Certificate	JI Deall I		Reg. No.			U
Physician /Medical		1. Decedent's Name (First, Middle, ILEE R. FULLE)					Month			. Time of	
/Medica	al					4h City Town on	AUGUST			4:15	PN
Examine	r	4a. Fecility Name (If not institution, g		TED	4b. City, Town, or CUMBERL.		h 4c. County ALLEG				
Funeral		MEMORIAL HOSPI 5. Social Security Number 217–10–4130	Sex 7. Age	AL CEN e (In yrs. lest I 84	birthday) If Under 1 Y		8 Date of Bir		9 Rirtholace	State o	r Forei
Director	-	Usuat Residence of Decedent		7-4	115.		sep 1	4, 1913	י כוניו		
Mo to	-	10a. State 10b. County 10c. City, Town or Location									ty Limi
te la	io	MD Allegar	ny	Ct	mberland					1X Yes	2 🗆 N
23a or 28	Funeral Director	10e. Street end Number 506 Woodside Av	enue		10f. Zip Co.	_{de} 502		10g. Citizen of V		?	
Examiner on	a by Funer	11. Maritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Amped Forces? 1 1 Yes 2 N If Yes, Give Year or Dates:	lo	13. Was Decedent tf Yes, specify 1 Yes 2	of Hispenic Origin? (S Cuban, Mexican, Puer No Specify:	Specify Yes or No to Ricen, etc.)	14. Rac Blac Specify	ce - Americen i ck, White, etc.	ite	
olical olical	ered	15. Decedent's (Specify only highest of	Education	16	ia. Decedent's Usuat O	ccupation one during most of wo	rkina	16b. Kind of B	usiness/Indust	ness/Industry	
Department of Health and Mental hygiena. Important: If Item 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumatic event, the Medical Examiner mant be notified at once. To Be Completed by Funeral Director	E I	Elementery/Secondery (0-12)	College (1-4or 5	+) 01	ille. DO NOT use re	one during most of wo atired)		PPG			
	3	17. Father's Name (First, Middle, La.	21)	0.	eder cuccin		me (First, Middle		no.)		
	0	Clifton Fulle	•			1	ouisa (V		10)		
27 is mar r traumet		19a. Informent's Name/Reletionship Geraldine Fulle			9b. Mailing Address (St 506 Woodsid				Stete, Zip Co.		
nent of Haz ant: If item ury or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donetion 5 Other (Spec		cemei	of Disposition (Neme of tery, cremetory or other et Memorial	place)	Date 08/07	20c. Location -	City or Town,		
Importa any inje		21. Signature of Furgeral Service Lic	and La	, all	22. Name and Ad Scarpe Cumber	elli Funer rland, MD	al Home, 21502	P.A.			
Medical xaminer	under l	Immediate Cause (Final disease or condition resulting in deeth)	b		a consequence of):	X tow	L		2	X	_
ettending physician and for use as the buriat-transit clan/Medical Examiner		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	c		a consequence of):						
ng phys	200	resulting in deeth) Last							1		
trending physics or use es the	Medic	resulting in deeth) Last	d								
od by the ettending physical by the ettending physical by the estimate of the physical by the etter of the et	rnysicianymedic	resulting in deeth) Last Part II. Other algnificant conditions		t not resulting	in the underlying cause	given in Part I.		tobacco use co	ntribute to the		
been signed by the should be detached	Dy Priysiciarymedic			t not resulting	in the underlying cause	e given In Part I.	1 🗆	- 1	3 Probabi	eutopsy fi ble prior to	Unkno
been signed by the should be detached	completed by ringsicial/medic	Part ii. Other algnificant conditions		t not resulting	in the underlying cause	e given in Part I.	1 🗆	Yes No en eutopsy prmed?	3 Probabil	eutopsy fi ble prior to	Unkno indings o ause
been signed by the should be detached	be completed by Physicial Medic	Part ii. Other algnificant conditions 25. Wes case referred to medical examiner?	contributing to death bu			26. Plece of De	24e. Was perfo	en eutopsymmed? Yes No	24b. Were available comple of deat	eutopsy fi ble prior to etion of ca	Unkno indings o ause
been signed by the should be detached	to be completed by Physician Medic	Part ii. Other algnificant conditions	contributing to death bu	nt 20dervo	Dutpatient 3□ DOA	26. Plece of De Other: 4 ☐ Nursing h	24e. Was perfo	en eutopsymmed? Yes No	3 Probabl 24b. Were availated comple of deat 1 Year (Specify)	eutopsy fi ble prior to etion of ca	Unkno indings o ause
been signed by the should be detached	to be completed by Physician Medic	25. Wes case referred to medical examiner? 1 Yes No. 27. Manner of Deeth 1 Netural 5 Pending	Hospital: 1 Inpatier 28e. Dete of Injur (Month, Day	nt 20dervo	Dutpatient 3 DOA Time of 28c. Injury	26. Plece of De	24e. Was perfo	en eutopsymmed? Yes No	3 Probabl 24b. Were availated comple of deat 1 Year (Specify)	eutopsy fi ble prior to etion of ca	Unkno indings o ause
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within 24 hours after deeth. To the Funeral Director: After this cardificate has been signed by the completaly illied in by the funeral director, page 2 should be detached. Medical Certification: To Be Completed by Physi	edical cer inication. To be completed by Physician Medic	25. Wes case referred to medical examiner? 1	Hospital: 1 Inpatier 28e. Dete of Injur (Month, Day) 28e. Place of Injur building, etc.	nt 20/ER/C y Year) 28b ry - At home, . (Specify)	Dutpatient 3 DOA Time of linjury M farm, street, factory, off pe, death occurred at the and/or investigation, in m 29c. Lice	26. Plece of De Other: 4 Nursing H injury at Work? 1 Yes 2 No ice e time, date and plece ny opinion, death occur	24e. Was performent of the control o	en eutopsy primed? Yes No one) dence 6 Oth how injury occurs Street end Numb wn, Stete) ceuse(s) and ma date end plece,	3 Probabl 24b. Were availated comple of death of the comple of death of the comple of the comple of the comple of the comple of the complete	eutopsy fi ble prior to etion of cath? es 2 oute Numi	Unknormalings Dause No
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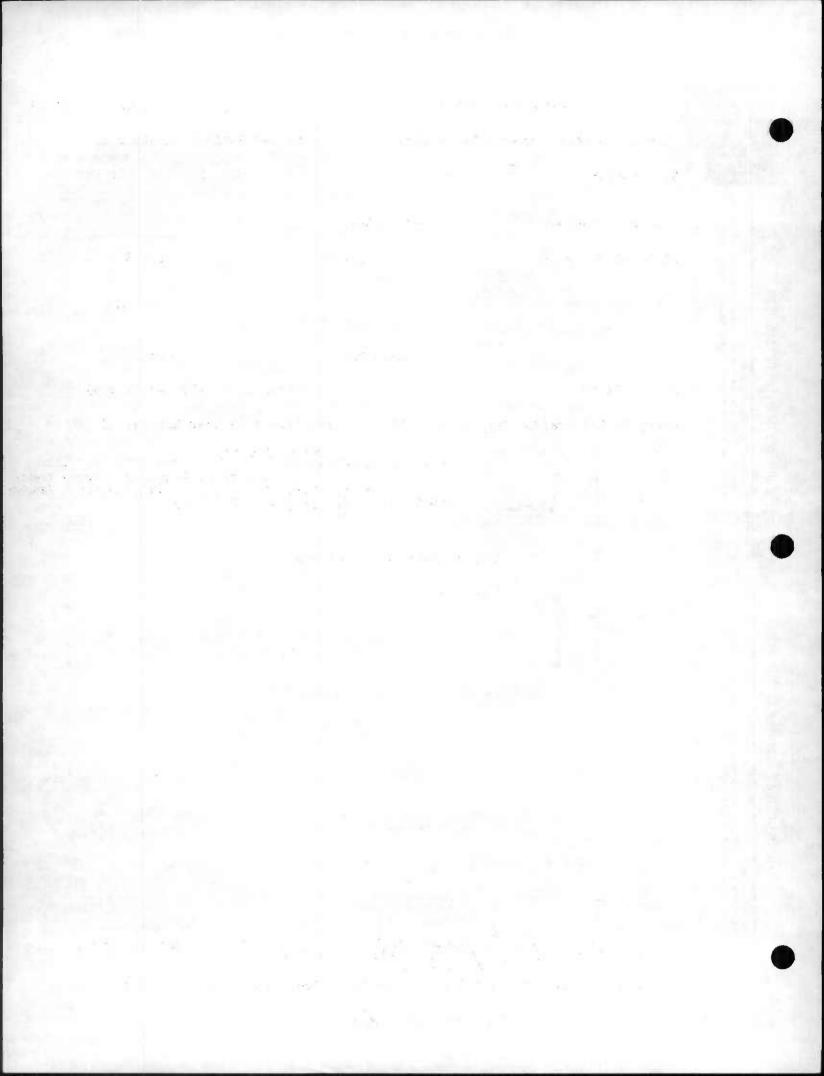


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State of Maryland / Department of Health and Mental Hygiene 98 27379

						Ce	rtifica	te of	Death		F	Reg. No.		, ,	, ,
		1. Decedent's Name								2.	Dete of Dea	ith	Wasa	3. Tim	e of Deeth
ı,	Physician		Ire	ne G. Fl	iakas						Month August	20, 19	998	6:3	35 PM
	/Medical Examiner	4e Facility Neme (If	not institution, giv	e street end numb	er)				4b. City, Towr	n, or Locat	ion of Deeth	4c. County	y of Death		
	Examino	Layhill	Center,	Genesis	Elder	Care			Silv	er Sp	oring	Montg	gomery	7	
	Funeral	5. Social Security Nu		_	Age (In yrs.	lest birthdey		r 1 Year Days		4 Hrs. 8. Min.	Date of Birt (Month, De)	h Veer)	9. Birthp	leca (Ste	nte or Foreign
	Director	577-44-87 Usuel Residence of	05	□ M XXF	85	Yrs.	Months	Days	Hours	Ma Ma	ay 15,	1913	Gree		
	yland	10a. Stata	10b. County		10c. City	y, Town or L	ocation						1	0d. Insid	e City Limits
	vith the Mar t or 28s-f st be notified Director	Maryland		ry	Sil	lver S	-					40- 0% /	147 0		/es 2X∏No
	Vith t	10e. Street end Num					101. 20	p Code				10g. Citizen of	What Cour	itry?	
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21215-0020	n 72 hours after deeth with the Maryland "natural", or items 23a or 28a-f show ad cal Examiner must be notilited at	11. Meritel Status 1 □ Never Merrie 3 ☒ Widowed		12. Was Decede Armad Force 1 Tyes 2 If Yes, Giva Year or Data	No No	,5. 13.			Hispenic Origin ban, Maxican, I Specify:	Puarto Ric	an, etc.)	Specil	ck, White,	etc.	
0	stura eate		15. Decedant's Ed			16a. Dece	dant's Usi	uel Occu	pation			16b. Kind of B			
215	led within 72 ho lygiene. Nor than "natura it, the Medical I	(Special Control of Co	fy only highest gra		or E . \	(Give	DO NOT	ork dona use retire	during most o	of working					
2	the principle of the pr	6	idary (0-12)	Collega (1-4	or 5+)	Hom	emake	r				Own I	Home		
D	be file tal Hys d othe evant, Be C	17. Fathar's Neme (First, Middla, Last)						18. Mother's	s Nama (F	irst, Middle,	Meiden Sumai			
Maryland	Menta Menta arked To E	John Bala	nis						Pat	ricia	a (N	ot Ava	ilable	2)	
ary	shour of the control	19e. Informent's Ne	me/Reletionship (Type, Print)		19b. Mail	ing Addras	s (Stree	t end Number	or Rurel R	loute Numbe	r, City or Town	, State, Zip	Code)	
Σ	alth a	Harry C.	Solomos	Son-in-L	aw	124	24 La	Pla	ta Stre	et,	Silver	Spring	e, MD	209	904
e,	uges 1 and 2 should be filed within to of Headth and Mental Hygiene. If them 27 is marked other than 'or other traumatic evant, the Mental Hygiene and the Complex To Be Complex to the Mental Hygiene and the Mental Hygiene 1 and	20e. Mathod of Disp	osition		20b. P	Plece of Disp	osition (Ne	me of			Deta	20c. Location		wn, Stet	9
Baltimore,	Peges nant of I ant: If Ite ury or of		Cremetion 3 ☐ 5 ☐ Othar (Spacif	Removel from Sta	ita	rt Lin		· A	ugust .	25, 1	998	Brentwo	nod N	via rw	land
	permit. Peg Department Important: I any Injury o	21. Significant of For			FOI					Rober		Pumphre			
B	permit. Departr Importe any Inje	1	130.		MOC	В	ethes	sda-	Chevy C Maryla	Chase	, Inc.	7557	Wisco	onsi	n Avenu
	NAME OF TAXABLE PARTY.	23a. Pert1. Enter th	e diseese, or com	plications the cau	sed the deet!	h. Do not er	iter tha mo	da of dy	ing, such es ca	ardiac or re	espiratory ar	rast,		Approxi	mata
l,	Physician	Shock, or near	railure. List only	one cause on aec	n ma.										Between and Deeth
	/Medical	Immediate Cause (F		Com	12 - D-			12-31							
	Examiner	disease or condition resulting in death)		e. Car	dio Re	r es a consa			ure				- 1		
	<u> </u>			Par	kinson		9441104 01	,					1		
- 8	The law requires that the death certificate be associed ate has been signed by the attending physicien end page 2 should be detached for use as the bunel-transit completed by Physician/Medical Examiner	Sequentially list con	ditions.	b		r es e conse	quenca of):							
oʻ	en en en en en en en en en en en en en e	Sequentially list con if eny, leeding to im- cause. Entar Under	mediete lying										i		
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ā	certificate rector, per	25. Wes case referre	ed to medical						26. Placa c	of Daath (C	Check only o	ne)			
>	Physician: this certific ral director,	examiner?	No	Hospital: 1 ☐ Inp	atient 2 🗆	ER/Outpetie	nt 3 🗆 🗅	OA OI	ther: 4 🖾 Nurs	sing Home	5 Resid	tenca 6 □Ot	har (Specif	(y)	
0	g Phys ar this neral di	27. Mannar of Death		28e. Deta of I	njury Dey Year)	28b. Time of	of	28c. Inju	ury at	280	d. Describe I	now injury occu	rred		
0	Attending is a death. •ctor: Attar by the funer iffication	1 XINatural 2 ☐ Accident	5 Pending Investigetion		Doy roan,	injury	М		Yes 2□N	0					
	Page Te	3 ☐ Suicide 4 ☐ Homicida	6 ☐ Could not be datermined	28e. Place of	Injury - At he atc. (Specify	oma, ferm, s	treet, facto	ry, offica		28f	Location (S City or Tox	Street end Num vn, Stata)	ber or Rure	ol Route	Number,
	To the Hospital within 24 hours within 24 hours To the Funeral completaly filled			ysician: To the be niner: On the basis and mannar	s of exemine										se(s)
1	within To the comple	29b. Signature and I	itle of certifier	0.0			25	9c. Lican	ise number			29d. Date sign	ed (Month,	Day, Yea	ar)
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	5	30. Name end eddra	ed hi pareon uha	completed cours	of death lite	23e) (Type	Print)	-	1 / 1			,,,,,,		((110
		Cezar A.						n Da	rive, O	lnev	Marir	land 2	20832		
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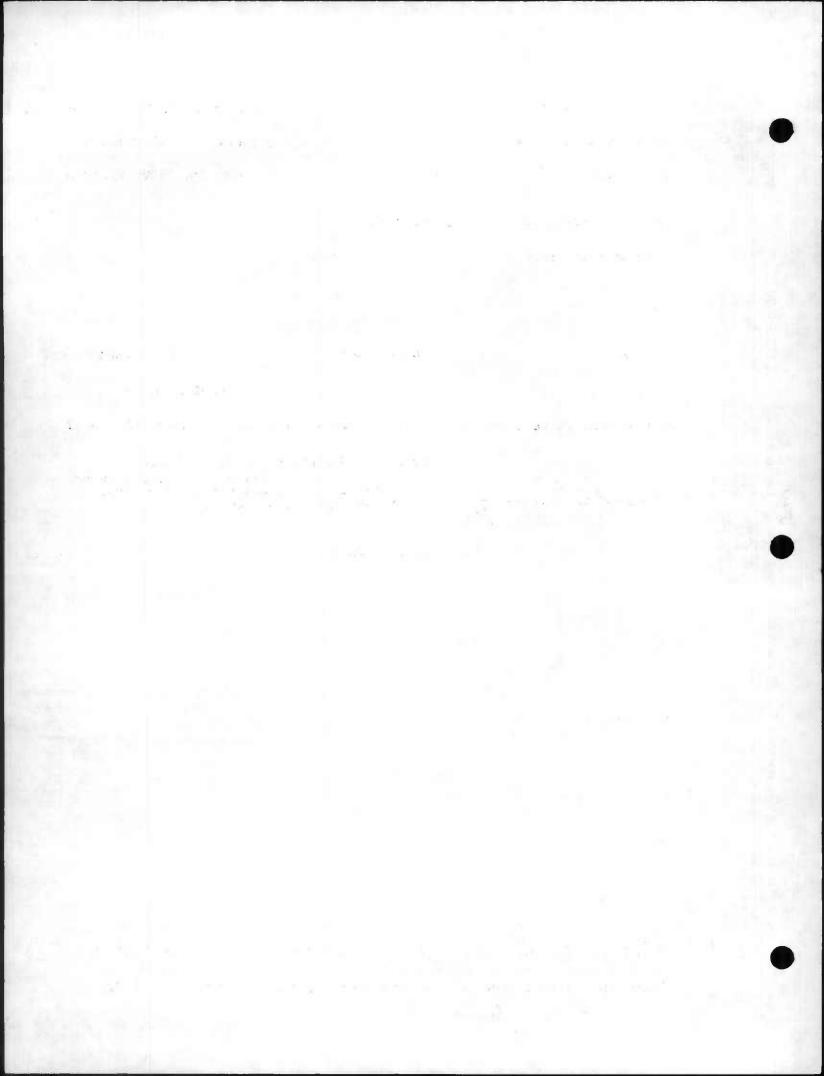


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State of Maryland / Department of Health and Mental Hygiene 9 8 27380

							Ce	rtificate	e of	Death			Reg. N	lo.		
			1. Decedant's Name (First, Midd	la, Last)								2. Data of Da		ey	Yeer	3. Tima of Death
	Physician /Modical		William L. Fo	ust,	Jr.							August	26	, 199		10:15 AM
9	/Medical Examiner	- 10	ta Facility Name (If not institution	n, giva strae	at and nun	nber)		-		4b. City, To	own, or L	ocation of Deel	-	c. County		
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la	Ment Ment arke		William L. Fo	ust							M	innie M	ae .	Jeffe	erson	
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altimore,	permit. Peges 1 end 2 Department of Health of Important: If Item 27 Is any Injury or other tra pnce.	-	21. Signature Funaral Sarvice	-		110	-					ancis J				
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State of Maryland / Department of Health and Mental Hygiene

	Decedent's Name (First, Middle, La	st)	Ce	rtificate	or I	Jeath	2. Date of D			. Time of Deeth
Physician	DANGE FISH	HERL					Month	Dey 1	Year QQS	1950
/Medical Examiner	4a Fecility Name (If not institution, give	e street end number)			4	b. City, Town, or	Location of Dea	th 4c. County	of Deeth	
	SUBURBA HOSPITA	n		Milladae	1 V	BETTHE			~0 wTGO	/
Funeral Director	5. Sociel Security Number 6. S 215-44-3612 Usuel Residence of Decedent	Sex 7. Age	(fn yrs. last birthday, 89 Yrs.	If Under Months		If Under 24 Hr Hours Mir		er 26, 190	9. Birthplace Country) Harri	sburg, P
yland	10a. Stete 10b. County		10c. City, Town or L	ocation					10d.	Inside City Limits
the Merylar 28a-f show notified rector	Maryland Montgome	ry	Potomac							1 ☐ Yes 2 ☐ No
or 28	10a. Street and Number			10f. Zip				10g. Citizen of V		?
23a rai	5 Alloway Court					854		U.S.		
ges 1 and 2 should be filed within 72 hours efter death with the Meryland it of Health and Mental Hygiene. If of Health and Mental Hygiene. If other traumatic syant, the Medical Examination must be notified an of other traumatic syant, the Medical Examination must be notified. To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yas 2 N If Yes, Give Yeer or Dates:		Wes Decede If Yes, speci 1 ☐ Yes 2		ispanic Origin? (n, Mexican, Pue Specify:	Specify Yes or N rto Rican, etc.)	Specify	e - American I ok, White, etc. : Whit	
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Hygie ther the the the the the the the the the the	12 17. Fether's Neme (First, Middle, Last	4	Elec	tricia	an	18 Mothar's No	ome (First Midd	e, Meiden Sumem		vernment
and the final H and out out out out out	Daniel Fisher						A. Coper		,	
market matic	19a. Informant's Name/Relationship (Type, Print)	19b. Maii	ing Address	(Street		-	ber, City or Town,	State, Zip Co	de)
nd 2 :	Martha Jean Metzde		5 AI	1oway	Con	rt, Pot	omac. M	20854		
f Head from other	20a. Method of Disposition		20b. Plece of Disp	osition (Nem	e of		Date	20c. Location -		, State
Page ent o nt: if ry or	1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special						houst 2	, 1998/R	ock Hall	MD
permit. Pages 1 and 2 Department of Health Important: if item 27 is any Injury or other tra ence.	21. Signeture of Funeral Service Lice	alelfel	10 2	2. Name and	Addre	ss of Fecility	Vewnam Fur	eral Home, yland 2162	P.A.	,
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the ett hed for red for	Part II. Other significent conditions		t not resulting In the	underlying ca	ause giv	en in Pert I.	23b. DI	d tobacco uae co	ntribute to th	e cause of death?
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sician: The lew certificate has b lirector, page 2 s o Be Compi							10	Yas 2 No	1 🗆 Y	es 2 No
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2 0 0	examiner? 1 XYas 2 □ No	Hospital:	nt 2 ER/Outpatie			4 LI Nursing		sidence 6 □Oth		
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Attending ir death. actor: After by the fune iffication	2 Accident investigation 3 Suicide 6 Could not be	00/14/	18 Inknow			Yes 2 No				
or At ofter of or by in by	4 Homicide determined		ry - At home, farm, s . (Specify)		, office		City or 7	(Street end Numl own, Steta)		
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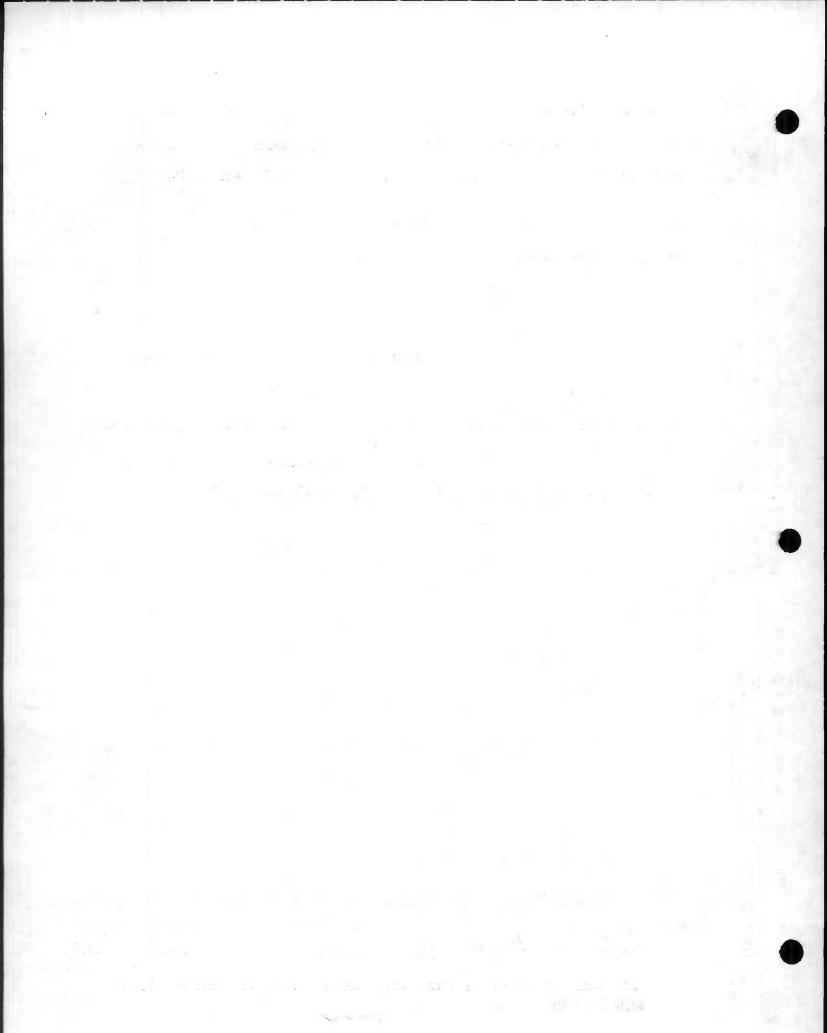
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State of Maryland / Department of Health and Mental Hygiene

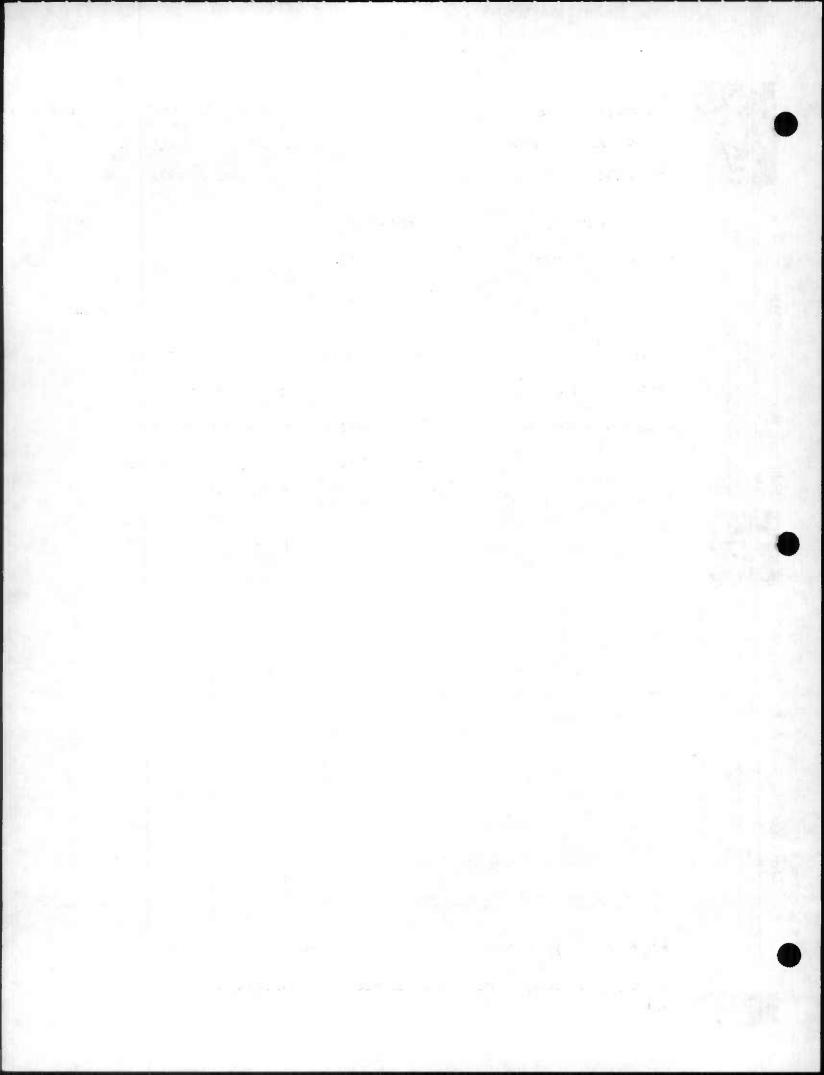
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Director		215-18-8540 Usual Residence of Dece		1□ M X □ F	76	Yrs.	Months	Deys	Hours	Min.	Apr 5	1922	2	WV	
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or 28	lire	10e. Street and Number					10f. Zip	Coda				10g. Citiza	n of What	Country?	
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or of		20a. Method of Disposition N Burial 2 ☐ Cren		Removal from		. Place of Disp cemetery, cre	metory or o	ther ple	ice)	į	Date	20c. Loca	ition - City	or Town, Stete	
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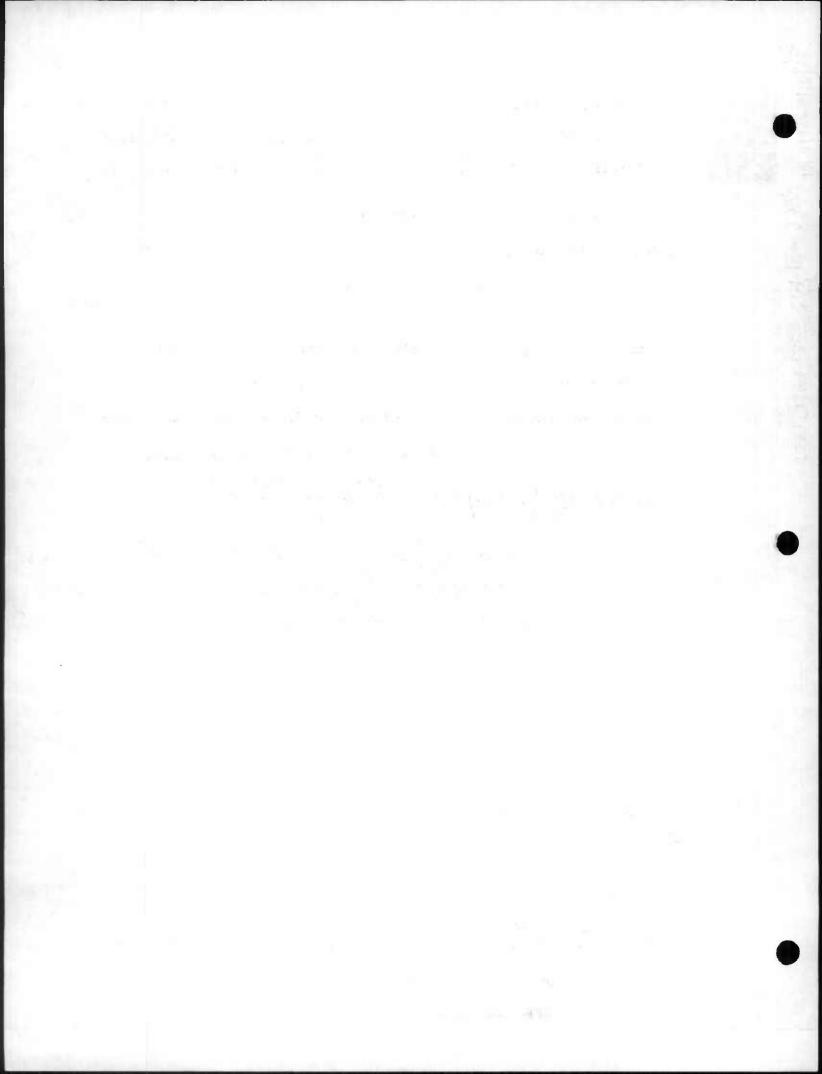


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Augh 10, 1998 M. Bernadine Grove 5:08 a.m. /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Berlin General Hospital Berlin Worcester 7. Age (In yrs. lest birthday) 73 Yrs. 8. Date of Birth 5. Social Security Number if Under 1 Year If Under 24 Hrs. 9. Birthplaca (Stete or Foreign **Funeral** 10 M 20 F Days Hours 219-14-7356 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notified at Allegany Cumberland 14 Yes 2 No **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12802 McMullen Highway 21502 USA items 23s 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indian, Bleck, White, etc. Grave, Bernadi ne 1345 " 1 Never Married 2 Married 1 Yes 2 No Completed by 3 ☐ Widowed 4 ☐ Divorced white 15. Decadent's Education (Specify only highest grede com 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Eiementan/Secondary (0-12) Special Ed. Teacher School Baltimore, Maryland 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Meiden Sumeme) Be 1 and 2 should be Health and Mental Stephen S. Boyle Anna Bernadine (Graham) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Harry W. Grove-husband 12802 McMullen Highway Cumberland MD 21502 Norm 27 20b. Place of Disposition (Neme of camerery, cremetory or other place)
Restlawn Memorial Gardens 08/13 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State LaVale MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Scarpellin Fulleral Home, P.A. Cumberland MD 21502 23a. Part1. Enter the disease, or complice shock, or heart failure. List only one Approximete Interval Betweer Onset and Deet Do not enter the mode of dying, such as cardiac or respiratory errest, **Physician** Immediate Cause (Finel disease or condition resulting in deeth) /Medical Examiner Examiner or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760 Physician/Medicai USB igned by the atte Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 4 Unknown 1 Tes 2 No 3 Probably þ 24b. Were autopsy findings eveilable prior to completion of cause of deeth? Completed 24a. Was en eutopsy page 2 certificete 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) Certification: To 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA this Menner of Deet 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After Natural 2 Accident 5 Pending Investigation efter death. 1 Tyes 2 No filled in by the 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours e To the Funeral E Hospital 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as steled. Medical 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. Signature and title of certific 10 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) m55 TOUTIM BSH252 31. Date filed (Month, Day, Year) 32. Registrar's Signature State ALIC 1 Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death 2352 **JOHN** AUGUST 1998 GRASSER 13 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death SALISBURY WICOMICO PENINSULA REGIONAL MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. Birthplace (Stete or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Dey, Year) Deys 11 M 2□ F 90 Yrs. 213-10-2919 March 4,1908 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. Stete 10b. County 1 ☐ Yes 21 No Maryland Wicomico Hebron 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 27295 Crooked Oak Lane 21830 USA Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 X Yes 2 No If Yes, Give WW II Yeer or Detes: WW II 1 Never Merried 2 Merried 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 → Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Controller Banking 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Frank G. Grasser May E. Brown 19a, Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Joan C. McDonald 27295 Crooked Oak Lane, Hebron, MD 21830 20b. Ptece of Disposition (Neme of cemetery, cremetory or other place) Dete 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 Donation 5X Other (Specify) Entertheent Wicomico Memorial Park 8/19/98 Salsibury, MD 21. Signature of Euneral Service Licens 22. Name end Address of Fecility Colloway Funeral Home tou th. Do not enter the mode of dying, such as cardiac or respiretory errest. MD 21804 Approximete Intervet Between Onset and Deeth Immediate Cause (Finel gstrubluse diseese or condition resulting in deeth) ran Due to (or es e consequence of) Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 15 Yes 2 No 3 Probably 4 Unknown 20 Lase

Physician /Medical Examiner

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Division of Vital

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Department of Health Important: If Item 27

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Baltimore, Maryland 21215-0020

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Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or injury that initieted events resulting in death) Lest Physician/Medical Completed

25. Was case referred to medical examiner?

1 Yes 2 No

27. Menner of Death

1 Neturel

2 Accident

3 ☐ Suicide

29e. Certifier

4 Homicide

(Check only one)

29b. Signeture end title

24a. Wes an autopsy performed?

2X No 1 Yes

24b. Were eutopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

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spitel: 1 Inpatient 2	ER/Outpatient	3X DOA	Other:	I ☐ Nursing H	ome 5 Residence 6 Other (Specify)
28e. Dete of tnjury (Month, Dey Year)	28b. Time of Injury	M 280	i. Injury et Work? 1 ☐ Yes	2 🗆 No	28d. Describe how injury occurred
28e. Plece of Injury - At h building, etc. (Speci	ome, farm, streety)	et, fectory, o	office		281. Location (Street and Number or Rural Route Num City or Town, Stete)

26 Place of Death (Check only one)

281. Location (Street and Number or Rural Route Number, City or Town, Stete)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the easis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, (Jky, Year)

7001126

30. Name and aberess of person who completed cause of death (Item 23a) (Type, Print)

BURTON m.o. 540 RIVEYSIDE Dr. SUME 8 31. Date fited (Month, Dey, Year)

State Registrar

AUG 1 9 1998

5 Pending investigation

6 Could not be determined

32. Registrer's Signature

Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient

Sparke

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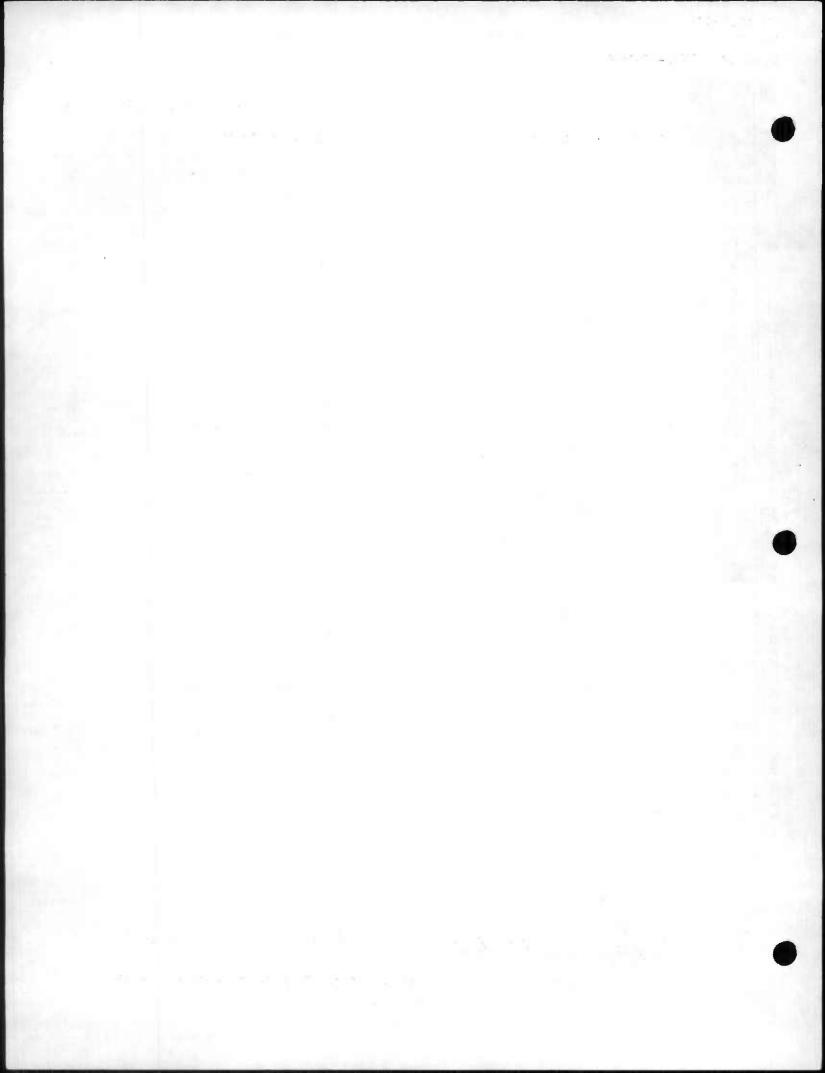
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ILLIAM DALE GARRISO	State of Maryland / Depa	artment of Health and Mental Hygiene 🛭 🦰	2738
	A-F PER MEO G763 9-11-98 WR. Cel	rtificate of Death	

I	TEMS: #23 P	ART I, 27, 28A-F PER ME 1. Decedent's Nama (First, Middle, Last		WR. Certif	ficate of	Death	2. Data of Das		3. Tir	na of Death
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020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mental Hygiene. Important: If itam 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumatic event, the Medical Examinet must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 ☑ Navar Marriad 2 ☐ Married 3 ☐ Widowad 4 ☐ Divorced	12. Was Decedant Evar Armed Forcas? 1 ☐ Yas 2 ☑ No If Yes, Giva Yaar or Datas:			Hispanic Origin? (S pan, Maxicen, Puar	Specify Yas or No- to Rican, atc.)		e - Amarican India k, Whita, atc. : : : White	ın,
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	/Medical Examiner	Immediata Causa (Final disaasa or condition resulting in death)	a	IANOL AND NAR to (or as a consequent		ITOXICATION			1	
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60,	be ax ician a burial	Sequentially list conditions, if any, laading to immadiata causa. Enter Underlying Ceuse (Disease or Injury	o							
x 68760,	law requires that the death certificate be executed as been signed by the attending physician and a 2 should be detached for use as the burial-transit npleted by Physician/Medical Examir	that initiated avants rasulting in deeth) Lest	Dua	to (or as a consequar	nce of):				1	
Box	death d for u	Pert li. Other algnificant conditions con	ntributing to death but no	ot resulting in the unde	riving causa g	ivan In Part I.	23b. Did t	obacco use co	ntribute to the ca	use of death?
, P.O.	as that the death ce igned by the attendi be detached for use by Physician/I	•					10	Yes 2□ No	3 Probably	4 Unknow
Records,	The law requira							an autopsy mad?	24b. Wara auto availabla p complatio of death?	prior to
æ	The lay page 2						13	as 2 No	1 Yas	2 No
ta	certificate rector, pag	25. Was cesa rafarred to medicel				26. Placa of Da	ath (Check only o	na)		
>	Physician: r this certific and director, r: To Be	axaminar? 1 XYas 2 No	lospital:	2 ER/Outpatient	3 DOA	thar: 4 Nursing I	Homa XX Rasio	lance 6 Oth	ar (Specify)	
Division of Vital	Attending Ph or deeth. ector: After thi by the funeral	27. Mannar of Death 1 Neturel 5 Pending 2 Accident invastigation	28a. Data of Injury (Month, Day Ye FOUND 8-18-98	ar) 28b. Time of Injury FOUND 9:01	P 28c. Inju	uryat ork?]Yas 2【∆No	28d. Dascribe h	now injury occur N	red	
Divis	To the Hospital or Attanding Physician: The I within 24 hours effer deeth. To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com	3 ☐ Suicida 6 🗶 Could not be datarminad	28a. Place of Injury - building, atc. (S FOUND A	and the second s	, factory, office		28f. Location (S City or Tow SILVER SF	Streat and Number State 111 PRING, MD	O MEURILE	Number LANE
	ne Hospitu n 24 houn ne Funera pletely fille edical C		sicien: To the best of my ner: On the besis of axa and mannar stated.	knowledge, deeth oo						usa(s)
	within To the comp	29b. Signatura and titla of certifiar	- Churto un	9		nsa number C.M.E		-	d (Month, Day, Ye 19, 1998	
		30. Name and address of person who co Dennis J. Chu	ompleted ceuse of death	(Itam 23a) (Type, Prin 111 Penn		, Baltimo	ore, Mary	vland 21	201	

Registrar

AUG 2 4 1998



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

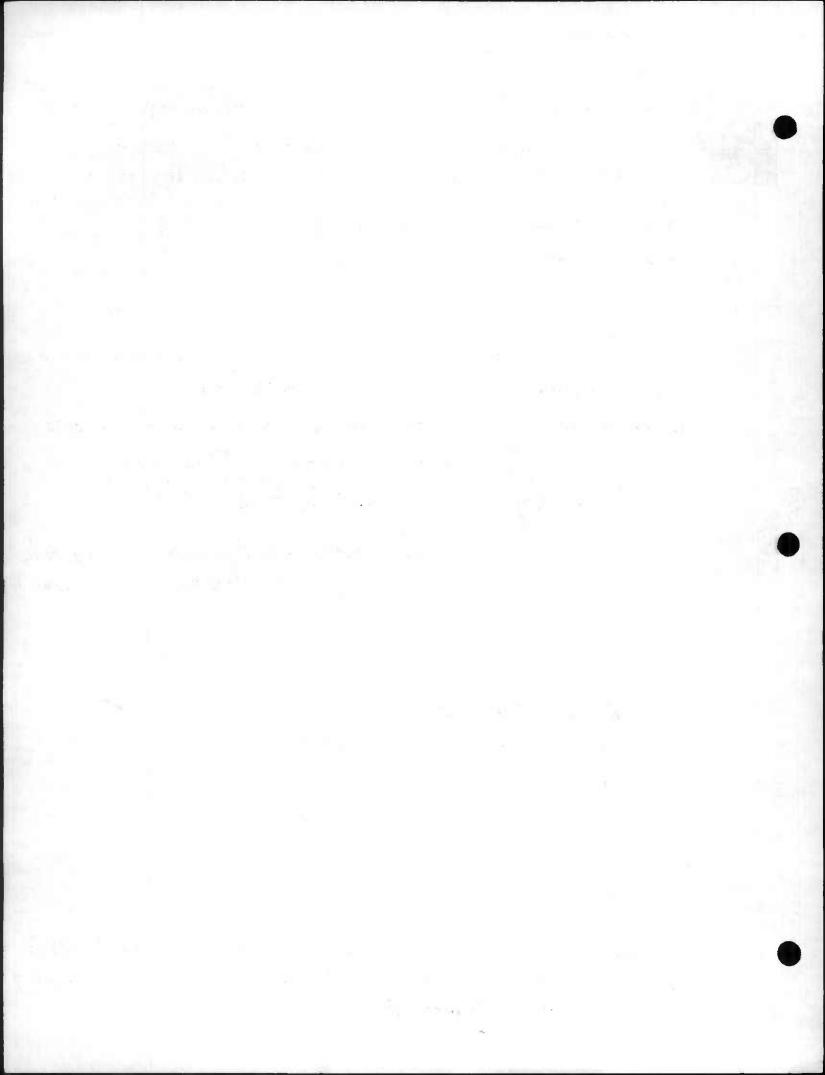
State of Maryland / Department of Health and Mental Hygiene 8

					Certificate of	Death	R	leg. No.		
LIKE IN		1. Decedent's Name (First, Middle,	Last)				2. Dete of Dee	th		3. Time of Deeth
Physic		GEORGIA IS	SABEL TUS	H GEN	HEIMER		AUG.		98	5:40 AM
/Medi Exami		4a. Fecility Neme (If not institution,	give street end number)			4b. City, Town, or L	ocation of Deeth	1		J.40 AM
LAGITI	161	RANDOLPH H	HTT.T.S MIIRS	ING HO	ME	WHEATO	M	MON	TGO	MERY
Ermanal				(In yrs. lest birt	1 7514 4 114		8. Date of Birth			
Funeral Director		271-46-4005	1□M 2 X F		rs. Months Deys	Hours Min.	(Month, Dey	, Year)		ace (State or Foreign ry)
		Usuel Residence of Decedent		95			APR. 20	6,1905	OH	10
and and		10e. Stete 10b. County		10c. City, Town	or Location				10	d. inside City Limits
f sh	5	MD	COMEDIA						1	Yes 2□No
1he 2	Director	MD. MONTO	GOMERY		ENSINGTON	N		0		
A P B					10f. Zip Code		1	0g. Citizen of Who	et Counti	ry r
ath 23	rai		ISCHER ST.			20895			S.A	
filed within 72 hours after death with the Maryland Hygiene. Then "natural", or flems 23e or 28e-f show ent, the Medical Examination number of	Funeral	11. Marital Stetus	12. Wes Decedent E Armed Forces?		 Was Decedent of F If Yes, specify Cub 	dispenic Origin? (Sp en, Mexicen, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Bleck,	White, et	
or I		1 Never Married 2 Married	1 ☐ Yes 24 No If Yes, Give	0	1□ Yes 20 No	Specify:		Specify:		
e filed within 72 hours aft af Hygiene. other than "natural", or vent, the Medical Exam	d by	3- Widowed 4 □ Divorcad	Year or Dales:					opeany.	WH:	ITE
72 h natu	Completed	15. Decedent's (Specify only highest of		16e.	Decedent's Usual Occup (Give kind of work done	petion during most of work	tina	16b. Kind of Busin	ness/Indu	astry
an .	de	Elementery/Secondary (0-12)	College (1-4or 5-		life. DO NOT use retire	d)	9			
gien gien	0	12			HOUSEWI	FE		AT	IOH	ME
other offier	Be (17. Fether's Name (First, Middle, La	st)			18. Mother's Nem	e (First, Middle, I	Maiden Sumame)		
should be ind Mental I	ToE	JAMES	WILLIAM	TUSH		н	AZEL	MAE	SMI	דיו
2 should and No.	-	19e. Informent's Neme/Relationship			Meiling Address (Street					
U 00 m 10								, ,		,
s 1 and 2 if Health item 27 I		BETTY V. ARC	JZ TAN/ DAUG		SAME A Disposition (Neme of	S ITEM		20c. Location - Ci	ty or Tow	n State
Pages nent of net: If its		1 Buriai 2 ☐ Cremetion 3		cemeter	, cremetory or other ple					
mer tant: jury		4 Donetion 5 Other (Spe	cify)	ROC	KLAND CEM	ETERY 8	/28/98	BELPR	E, (OHIO
permit. Pages Department of Important: If is any injury or once.		21. Signature of Funeral Service Lig	ghood /		22. Name end Addre	ess of Fecility		* TT 17 TD (מת כ	ING, MD.
8 5 5 5 8		1/1/1/1/KO	merical	M00091	CHAMBERS	FIINEDA	T. HOMES	S D V		
		23a. Pert1. Enter the disease, or co shock, or heert feilure. List on								20910 Approximete
Physician		shock, or heert feilure. List on	ly one cause on each line	θ.						intervel Between Onset and Death
/Medical		Immediete Ceuse (Finei			. 0	-0 %	2. 2	_		77
Examiner		diseese or condition resulting in death)	e. Cle	ele a	nyscarle onsequence of):	at cape	arello	an a		menuces
	<u>-</u>			Due to (or es e c	onsequence of):	-				
ped lisit	Examiner		b							
ertificate be executed ling physician and se es the burial-transit	хаг	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying	D	Due to (or es e c	onsequenca of):					
cian		cause. Enter Underlying Ceuse (Diseese or Injury	C							
physician and s the burial-transit	edical	thet initiated events resulting in deeth) Last	D	ue to (or es e co	onsequence of);					
o se	Mec									
attending p			d			-				
e att	lois	Pert II. Other significent conditione	contributing to death but	not resulting in	the underlying cause giv	ven in Pert I	23b. Did to	obacco uee contri	bute to t	the cause of death?
igned by the attend be detached for us	Physician			1						ably 4 Unknows
bed t	by P	progress	ive de	nerle	a"		. 104	98 &L3140 3	_ FIOUR	- → □ OHRHOW!
as been signed by the 2 should be detached							24e. Wes e	n eutonsv	24b. Wer	e autopsy findings
been sig	ete						perform		evel	leble prior to
has b	du								of de	pletion of cause seth?
	Completed						1 □ Y	95 2 NO	1 🗆	Yes 2 No
certificate rector, pa	Be (25. Wes case referred to medical				28. Piece of Deet	h (Check only on	10)		
ls ce direc	0	exeminer?	Hospitel: 1 Inpatien	t 2 ER/Out	petient 3 DOA Oth	ner: 4 Norsing Ho	ome 5 Reside	ence 8 Other	(Specify)	
eral	T:U	27. Menner of Deeth	28e. Dete of Injury	28b. Ti	me of 28c. Injur			ow injury occurred	, /	
Attending Proyscians, or death. •ctor: After this certific by the funeral director.	tlo	1 ☑Neturel 5 ☐ Pending investigat	(Month, Dey	Y <i>ear)</i> In		Yes 2 □ No				
efter death. Director: Af	Certification:	3 ☐ Suicide 6 ☐ Could not	be One Place of Injur	rv - At home, fer	n, street, factory, office		28f. Location (St	treet and Number	or Rural i	Route Number.
olre in 5	Te	4 ☐ Homicide determine	building, etc.	(Specify)	n, oliooi, raololy, olioo		City or Town			
within 24 hours e To the Funeral C completely filled		20-0-45				1				
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the la	8	one)	end menner state	ed.						
within 24 hours efter To the Funeral Direc completely filled in by	Σ	29b. Signature end title of certifier	1 /		29c. Licens		2	9d. Dete signed (i	-	ay, Year)
2		MAI AS	delle		DO	9874		8/24/	58	
8		30. Neme end eddress of person wh	o completed cause of de-	eth (Item 23e) (1						
		BARRY ROSENBI		_	AGOT AUE	KENISIN	670N,	MS 20	825	
Sta	te	31. Dete filed (Month, Day, Year)	32. Registrer	's Signeture	, ,					
Registr	_	AUG 25		war	G. Spor	la la				
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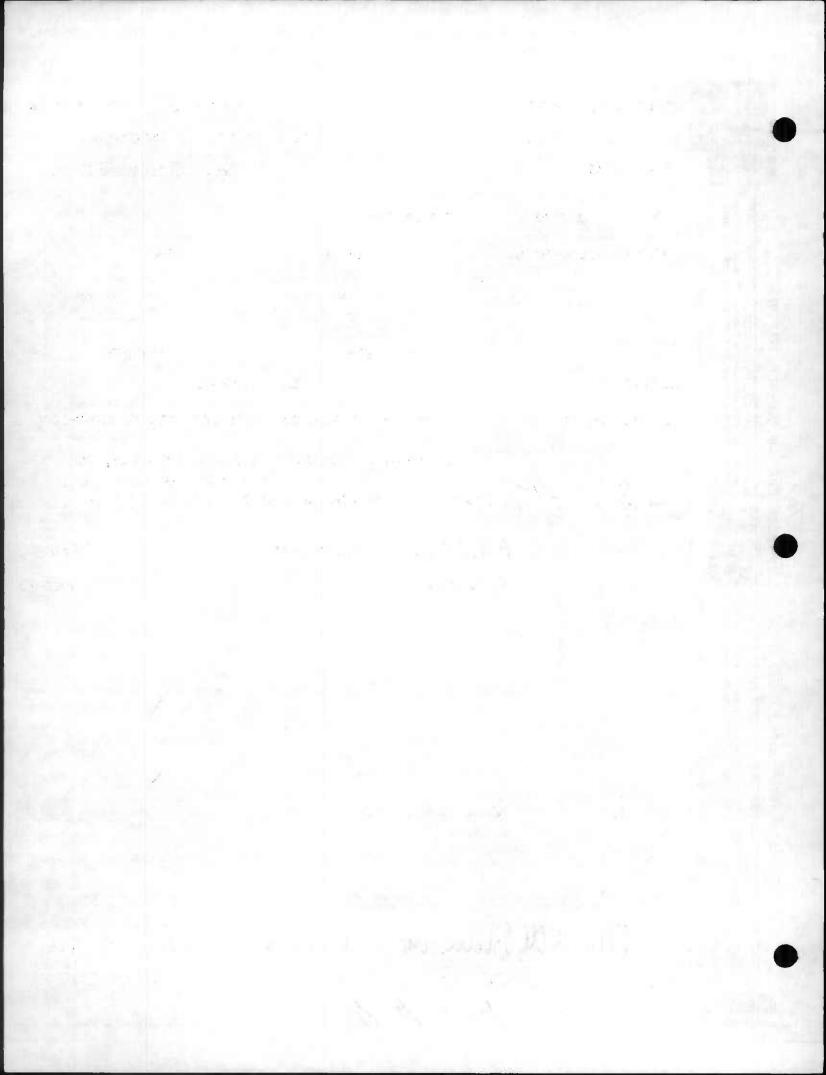
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Physician	1	. Decedent's Name (First, Middle	le, Last)		Cel	tificate of	Death	2. Date of Deat	eg. No.	3. Time of Deet
	ľ	Hugh F. Ging	erich					Aug. 26	, 1998 Y	11:35P
/Medical Examiner	41	a. Facility Name (If not institutio	n, give street end num	ber)			4b. City, Town, or L		4c. County of	
		Manor Care -	- Bethesda				Chevy Cha	SP	Montgo	merv
uneral	5.	Social Security Number	6. Sex 7	. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth (Month, Day,		Birthplace (State or Ford Country)
ector		577-60-6667	1 (x M 2 □ F	81	Yrs.	Working	TIOUTO IVIII.	Oct.14,		lichigan
ed at	-	0a. State 10b. County		10c. Cit	ty, Town or Lo	cation				10d. Inside City Lin
23a or 28a-f shows that the confidence of the co	M		gomery		Silv	er Sprin	g			1 □ Yes 2 🔯
Dire	10	0e. Street and Number				10f. Zip Code		10	0g. Citizen of Who	at Country?
oral	1	.0023 Menlo Ave				209			USA	
Examiner must by Funeral	•	Marital Status Never Married 2⊠ Mar Widowed 4 □ Divorced	If Yes Give	es? No		Nas Decedent of f Yes, specify Cut	Hispanic Orlgin? (Spoen, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)		American Indian, White, etc.
office		15. Deceder	nt's Education est grade completed)		16a. Deced	lent's Usual Occu	pation		16b. Kind of Busin	
out, the Medical is Completed		Elementery/Secondary (0-12)	College (1-	4or 5+)			during most of work ed)	ing		
S S	-	7 Fathada Nassa /Fins Afiddle	5+		P	lathemat:				Government
Be C		7. Father's Name (First, Middle,					18. Mother's Nam	e (First, Middle, N a Kauffm		
7 is merked other traumatic event, I To Be Co		Solomon Ging 9a. Informant's Name/Relations	serich		19b Mailin	n Address (Stree	at and Number or Rur			ate 7in Code)
2 4		Cerrence Irelan		end)						land 20910
or other		Da. Method of Disposition		20b. F	Place of Dispo-	sition (Name of natory or other pla			20c. Location - Cit	
Important: if It any Injury or one		1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (S		ate	-	itan Crei	1 2	3/28/98	lovendrd	a Wimainia
Important: i any injury o once.	2	1. Signatuserot Fürjeral Servica		rie			ess of Fecility Fra	ncie I	Colline	a, Virginia
any le		1 Hhn K	00%		Ho	me, Inc.	500 Univ	ersity E	Slvd. Wes	st
	2	23a. Purty Enter the disease, or heart failure. List	complication that car	used the deat	th. Do not ente	er the mode of dy	ing, such as cardiac	or respiratory arre	est,	Approximete
ician		or near failure. List	only one or me on ea	on line.	1	1			,	Interval Between Onset and Deeth
dical	lr d	mmediate Ceuse (Final			110	pi yati	in nne	umm	12	111100
niner	re	esulting in death)	A	Due to (d	or as a conseq	vence of):	in prie	1	,	1000
sit	П		a b		Ha	VKin	son's	Mureu.	re	10 yeur
buriel-trensit	S	sequentially list conditions, any, leading to immediate ause. Enter Underlying		Due to (c	or as a conseq	uenca of):				
	C	ause (Disease or Injury	c							
Sta Bay		net initieted events esulting in death) Last		Due to (o	or as a consequ	uenca of):				
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d for	P	art II. Other significent condition	one contributing to dee	th hut not res	ulting in the ur	deriving cause of	iven In Part I	23h Did to	hacco use contri	ibute to the cause of de
ed by the ettandin detached for use y Physician/N	1.	art II. Other significant condition	ons contributing to dea	th but not les	•	idenying cause gi	wen in Fan I.			Probably 4 Unki
be det	-	200	ng ca	ren	1 - 1	7				E (. coss)
should should		Chva	ite Obs	tric	tivef	u/mar	nary	24a. Was er perform	n autopsy ned?	24b. Were eutopsy finding eveilable prior to completion of cause of death?
page 2		Div	eure					1□ Ye	s 20 No	1 ☐ Yes 2 ☐ No
s certificate director, pag	2	5. Was case referred to medica exeminer?	1				26. Place of Deat	h (Check only one	θ)	
S D D	_	1 ☐ Yes 2 No			ER/Outpatien	1 3LI DOA		me 5 🗆 Reside	nce 6 Other	(Specify)
E = -	27	7. Manner of Deeth 1 Natural 5 ☐ Pendir		Injury Day Year)	28b. Time of Injury	28c. Inju		28d. Describe ho	w injury occurred	
章章 【二】		2 Accident Investig	not be				Yes 2□No	not Iti (Ot		
After thi funeral		4 ☐ Homicide determ	ningd 200. FIECE 0	f Injury - At his, etc. (Specif	ome, farm, stre fy)	et, fectory, office		City or Town	, State)	or Rural Route Number,
After thi funeral funeral										
After thi funeral funeral	2	9a. Certifier Certifyln (Check only one)	ng Physician: To the b Examiner: On the bas	is of examine	owledge, death stion and/or inv	occurred et the trestigation, in my	ime, dete and place, opinion, deeth occur	and due to the ca red et the time, da	use(s) and menn ate and placa, and	er es steted. d due to the cause(s)
funeral		(Check only 2 Medical	ng Physician: To the b Examiner: On the bas and manne	is of examine	owledge, death and/or inv	estigation, in my	opinion, deeth occur	red et the time, da	ate and place, and	d due to the cause(s) Month Day Year)
completely filled in by the funeral Medical Certification: 7		(Check only one)	ng Physician: To the b Examiner: On the bas and manne	is of examine	owledge, death etion and/or inv	estigation, in my	opinion, deeth occur	red et the time, da	ate and place, and	d due to the cause(s) Month Day Year)
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至	25	(Check only one)	ng Physician: To the b Examiner: On the bas and manne	is of examine ir stated.	and/or inv	estigation, in my	opinion, deeth occur	red et the time, da	ate and place, and	d due to the cause(s)



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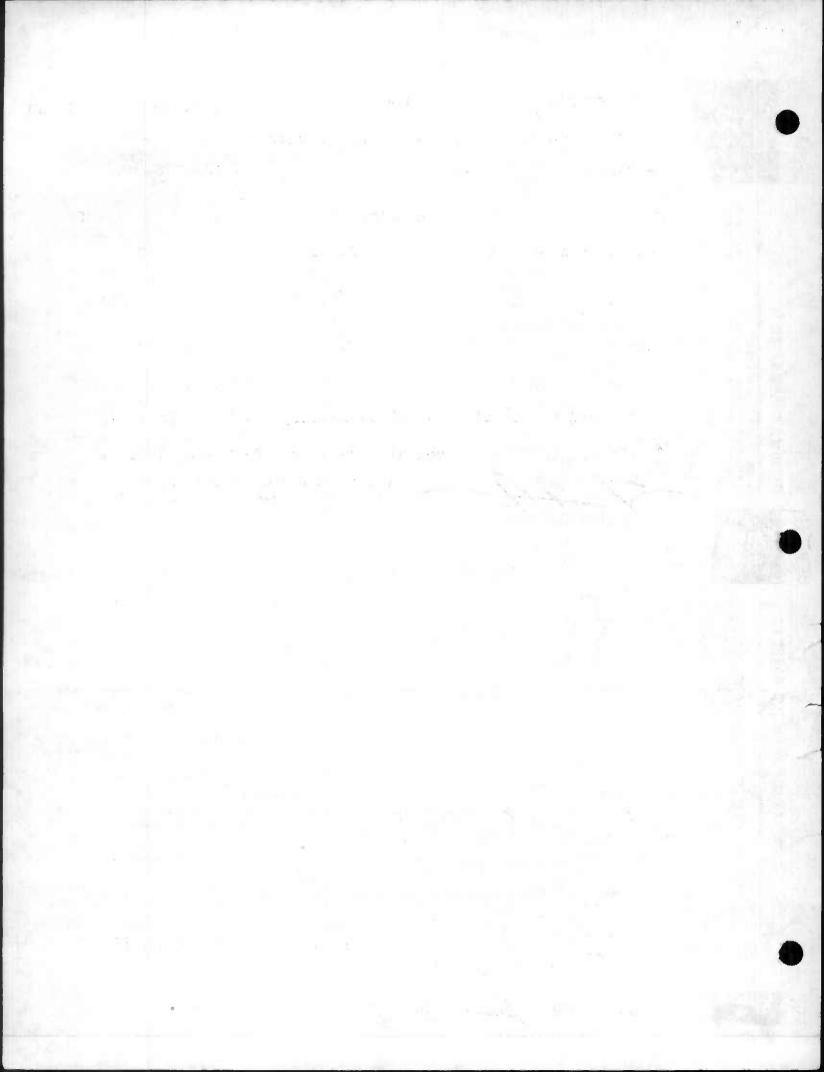
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Physician		ame (First, Middle, Last)						2. Date of Do Month	Day	Year				
/Medical	THEODO:	RE JOHN GOO)			4b. City. Town.	AUGUST or Location of Dee		1998 6:30 ar	n			
Examiner		ROSS HOSPIT					SILVER	GOMERY						
offer deeth with the Maryland inter deeth with the Maryland inter must be notified at street must be notified at Funeral Director	5. Social Security 578-07-	-3135 X		ge (In yrs. 93	last birthday) Yrs.	If Under 1 Yes Months Dey		lin. 8. Date of Bi	9. Birthplace (State or Forei Country) 4 New Jersey	ign				
	10a. State													
	10e. Street and N		EKI	IA	NOMA P	10f. Zlp Code			10g. Citizen of V	1X Yes 2 N				
deeth with	7312 (GLENSIDE DR				2091	2		USA					
215-002(bin 72 hours a n "naturel", o wedieted by	3 -Widowed	arried 2 Married 4 Divorced	1 ☐ Yes 2 ☐ No			Yes, specify Co		(Specify Yes or Neerto Rican, etc.)	Specify	ck, White, etc.	e, etc.			
	(Sp Elementary/Se 12	15. Decedent's Educecify only highest grade acondary (0-12)	5+)	(Give life. I	lent's Usual Occ kind of work dor DO NOT use reti	usiness/Industry VATE								
be file dother event.	17. Father's Nem	ne (First, Middle, Last)						Name (First, Middle A DEMPSK)	, Maiden Sumen					
Aar 2 sho end is m	19a, Informant's	Neme/Relationship (Ty) N MORRIS	oe, Print)				et and Number of	State, Zip Code) MD 21042-5004						
Z 25 25 Z		isposition 2 Description 3 R 5 Other (Specify)	0	em etery, cren	sition (Neme of netory or other p	olace)		ation - City or Town, State						
Baltil permit. P Departm importar any injur										FUNERAL HOME, INC.				
	23a Pert1. Ente shock, or h	r the disease, or compli eart failure. List only or			n. Do not ent	er the mode of o	lying, such as cere			Approximate Intervel Between Onset and Death				
Physician /Medical Examiner	Immediate Caus disease or condi resulting in deatl	ition	a. ASPIRATION PNEUMONIA 24 HOURS STROKE 3 WEERS											
be sit			ST	PDV to (o	r as a consec	uence of):			100	3 WEEK	25			
68760, ficate be executed physician end as the buriel-transit edical Examiner	Sequentially list if any, leading to cause. Enter Un Cause (Disease Ihal initiated eve	conditions, immediate iderlying or injury	Due to (or as a consequence of): Due to (or as a consequenca of):											
X 68760, certificate be exiding physician sa as the burie	resulting in death	nts n) Last												
death cert e attending ed attending ed for use	Part II Other elg	nificant conditions con	tributing to death I	nut not rose	ulting in the un	dorbular course	civen in Red I	23h Die	I tobacco use co	ntribute to the cause of dea	dh2			
S, P.O. Box as that the death cert igned by the attending be detached for use a	Patt II. Other sig	milicant conditions con	thouting to death t	out not rest	arting in the di	idenying cease	given in Peict.		Yes 2 No	3 Probably 4 Unknown				
Cord requir been s should									s an autopsy ormed?	24b. Were autopsy finding available prior to completion of cause of deeth?	js			
Vital Relations The lever certificate has irector, pege 2								10	Yes 2 No	1 ☐ Yes 2 ☐ No				
f Vital Ruystclan: The lis certificate hadirector, pege	25. Was case refearminer?	ferred to medical	26. Plece of Death (Check only one)											
- S 00	1 ☐ Yes 2	No	ospital:		ER/Outpatier	T 3LI DOA		4LI Nursing Home 5LI Hesidence 6 Li Other (Specify)						
Division of Vital or Attending Physician: The effer death: Director: After this certificate in by the funeral director, pertification: To Be Coertification: 27. Menner of De	5 Pending Investigation	28a. Date of Inj (Month, De	ey Year)	y Year) 28b. Time of Injury M 28c. Injury at Work? 1 □ Yes 2 □ No										
Division or To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral Medical Certification:	3 ☐ Suicide 4 ☐ Homicid	6 ☐ Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street er City or Town, Stete							ber or Rural Route Number,				
Hospi 24 hour Funer letely fil	29a. Certifier (Check only one)	1 Certifying Phys		of examinal						enner es steted. and due to the ceuse(s)				
To the vithin To the comple	29b. Signature a	nd tale of certifier	1181		(11		ense number			ed (Month, Dey, Year)				
6	-	mull	M MM	m	MD	D	31563		AUGUST	20, 1998				
	30. Name and ad	Idress of person who co	ENNER	death (tterr	23a) (Type,	Print)	14 WOOT	DRIV	E, SIL	720, 1998 NERSPRING				
State Registrar	31. Date filed (M	onth, Dey, Year)		rar's Signa	G.	Soon	61		,					



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sician		. Decedent's Name (First, Middle, KATHERGE		CD	ANT		2, Date of De Month	Day	Year 3. T	ime of Death		
edical	-	a. Facility Name (If not institution,		GR	4b. City, Town, or L		9-1998		:30 AM			
miner			omas More	Nursing	Home	Hyattsv		PG	Of Death			
ral tor		262-28-3058	5. Sex 7. Ag	a (In yrs. last birthda) 75 Yrs.	/) If Under 1 Year Months Days		8. Date of Bir 1 1 - 1 8 -	1922	9. Birthplace (State or Forei			
Item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, the Medical Experience must be notified at To Be Completed by Funeral Director		Jsual Residence of Decedent Oa. State 10b. County		10c. City, Town or I	_ocation				10d. Ins	side City Limits		
		DC		Waswhington					1X Yes 2 No			
	1	0e. Street and Number 1 Walnut Str	eet, NW		12			g. Citizan of What Country? US				
		1. Marital Status 1 Never Married 2 Married 3 Widowed AD Divorced	12. Was Decadant Armed Forces? d 1 Yes 2 4 If Yes, Give Year or Dates:		. Was Decadent of If Yes, specify Cut 1 ☐ Yes 2 2 No	Hispanic Origin? (Sp ban, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	- 14. Rac Blac Specify	e - Amarican Indi ck, White, etc.			
		15. Decedent's (Specify only highast	Education grada completed)	16a. Dec	edent's Usuel Occu	pation during most of work ed)	kina	16b. Kind of Bu	nd of Business/Industry			
		Elementary/Secondery (0-12)	College (1-4or 5	i+) life.	DO NOT use retire	k		Unknow	nown			
		7. Father's Name (First, Middle, Le John	Heard				e Wash	ington	gton			
		9a. Informant's Name/Relationship Amos Heard				reet, NV						
	2	0a. Method of Disposition 1 □ Burial 2√□ Cremation 3 4 □ Donation 5 □ Other (Spe		20b. Placa of Disp cemetary, cri Riverda	atory (Data 08-19-9		City or Town, St.				
8500 B	0	11. Signature of Funeral Service Lic	onses /			Funeral Home						
	1	23a. Pasti- Enter the disease, or co shook, or heart fallure. List on	omplications that caused	the death. Do not er						oximate al Between		
an al er	1	mmediate Cause (Final lisease or condition esulting in death)	Card	diac Arre	est				Onset	ninute:		
ine in			Respiratory Failure 10 minut									
i Examiner		sequentially list conditions, any, leading to immediata ause. Enter Underlying ause (Disease or Injury nat Initiated events	Due to (or as a consequence of): Arrythmia									
n/Medical	ľ	nat Initiated events esulting in death) Last	d	Dua to (or as a consequence of):								
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by Phys	-		Failure				1 □ Yes 2 No 3 □ Probably			4 Unknown		
mpleted by Physician/Me	-	Hepati	ic Failure	9			24a. Wes perio	an autopsy med?	24b. Were eute available complatio of death?	prior to on of cause		
Die							101	es 20 No	1 ☐ Yes	2□ No		
Comple				26. Place of Deeth (Check only one)								
Ве Сотр	2	5. Was case referred to medical examiner?	Henrikel (ent 3 DOA	her: 4 Nursing Ho	Ing Home 5 ☐ Residence 6 ☐ Other (Specify)					
To Be Comp	2	exa <i>m</i> iner? 1 □ Yes 2 No	Hospital: Inpatie		of ODe Init	mr. a4	and December b	28d. Describe how Injury occurred 28f. Location (Street and Number or Rural Route Number,				
To Be Comp	2	examiner? 1 Yes No 7. Manner of Death 1 Neturel 2 Accidant 3 Suicide 6 Could not	28a. Date of Injui (Month, Day	y Year) 28b. Time Injury	M 1]Yas 2□No			er or Rural Boute	Number		
Certification: To Be Comp	2	examiner? 1 Yes No 7. Manner of Death 1 Neturel 5 Pending Investigat 3 Suicide 6 Could not determine	28a. Date of Injurion Loe and Date of Injurion Loe and Date of Injurion Date of Date of Injurion Date of Date	y Year) 28b. Time Injury ary - At homa, farm, s . (Specify)	M 1 [Yas 2 No	28f. Location (S City or Tox	Street and Numb m, State)		Number,		
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To Be Comp	2	examiner? 1 Yes No 7 Manner of Death 1 Neturel 5 Pending Investigat 3 Suicide 6 Could not determine 9a. Certifier Check only 2 Medical Ex	28a. Date of Injur (Month, Day 28a. Place of Injur building, etc. Physician: To the best of aminer: On the basis of	y 28b. Time Injury iny - At homa, farm, s. (Specify) if my knowledge, dea examination and/or it	M 1	Yas 2 □ No ima, date and place, opinion, deeth occur sa number	28f. Location (5 City or Tow and due to the red at the time,	Street and Numb m, State) causa(s) and ma date and place, s	nnar as stated.	iuse(s)		

DHMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Month MARGARET ISABEL CORE AUGUST 1998 02:08 PM /Medical 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner WORCESTER BERLIN NURSING & REHABILITATION CENTER BERLIN If Under 1 Year
Months Deys 8. Date of Birth (Month, Day, Year APRIL 7, 1 5. Sociel Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** Birthplace (State or Foreign Country) 1□M 2XF Hours 90 Yrs Director 209-14-6274 1908 MARYLAND Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director DELAWARE SUSSEX SELBYVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? RD 2 BOX 225-67 19975 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Year or Dates: 11. Marital Status 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indian, Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: by 3 Nidowed 4 Divorced Specify: WHITE Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 OPERATOR TELEPHONE permit. Pages 1 and 2 should be file Department of Health end Mental Hy Important: if flem 27 is marked other any lighty or other treumstic event, potes. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) 2 V. JOSEPH GUTHRIE MARGARET ANDERSON S. 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ARLENE V. REELEY/DAUGHTER RD 2 BOX 225-67, SELBYVILLE, DELAWARE 19975 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 8/26/98 BERLIN, MARYLAND 4 Donetion 5 Other (Specify) **EVERGREEN CEMETERY** 21. Signeture of Funeral S 22. Name end Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DELAWARE 19975 Type, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, it is only one cause on each job. Approximate Intervel Between Onset and Death Physician racerebeal Hemorrhage /Medicai Immediate Cause (Finel diseese or condition resulting in death) Examiner Due to (or as e consequence of): Examiner Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in deeth) Last Due to (or es a consequence of) Physician/Medical Due to (or es a consequenca of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown by Be Completed 24a. Was an autopsy performed? 24b. Were eutopsy findings available prior to completion of cause of death? 25. Was case referred to medical 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 NO NO Other: 4 Nursing Home 5 Residenca 6 Other (Specify) P 1 Yes 2 ER/Outpetient 3 DOA 27. Menner of Deeth 28a. Dete of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Pleca of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred et the time, dete end place, and due to the cause(s) end manner es stated.

2 Madical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end placa, end due to the cause(s) end manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 39. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) GREGORIO M. BELLOSO, M.D. 5302 CHINABERRY DRIVE, SALISBURY, MD Z1801

State Registrar 31. Dete filed (Month, Day, Year) AUG 2 4 1998 Registrar's Signeture

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page 2

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To the Funeral C the Hospital

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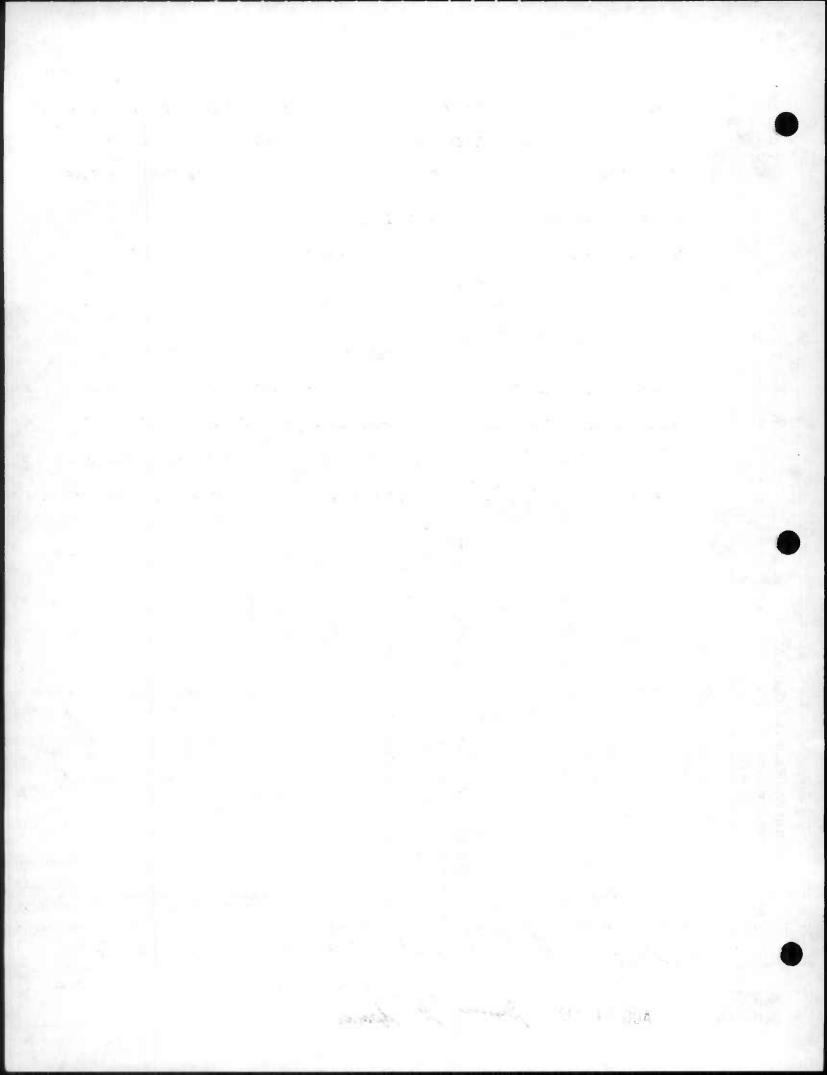
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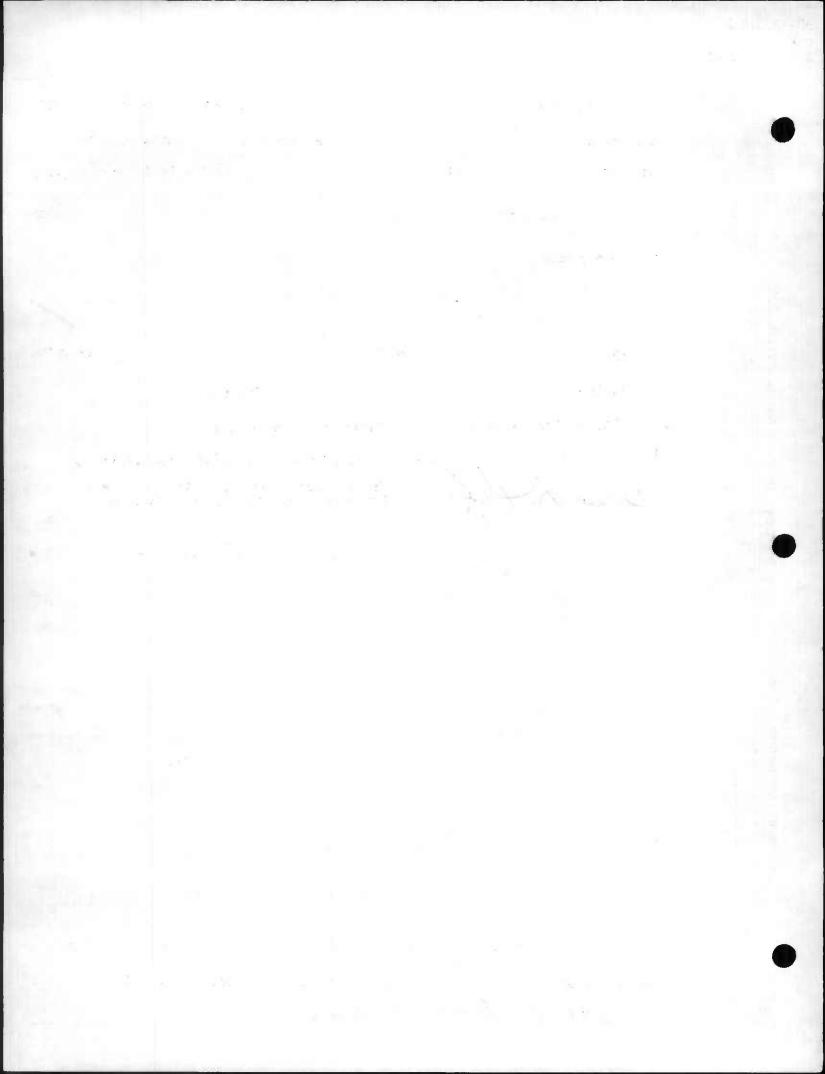
Baltimore, Maryland 21215-0020



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State of Maryland / Department of Health and Mental Hygiene

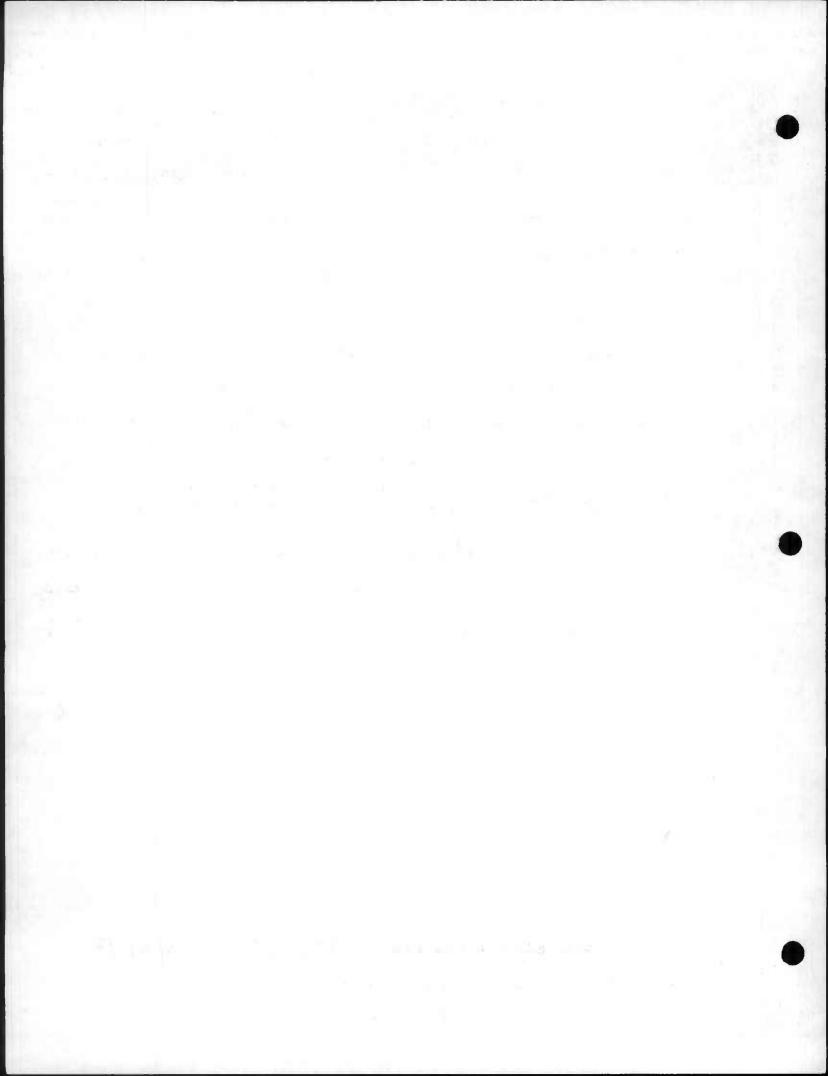
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ral tor	5. Social Security Nu 204–14–41	85	Sex 7. Age (In yrs. lest birthday) If Under 1 Year If Under 1 1 Year If Under							ete of Birth Month, Pay, 2C	h. Day, Yeer) Country)				
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		Grubb							elma						
	19e. Informent's Ner				19b. Maili	ing Addres	ss (Street	end Number o	r Rurel Ro	ute Number	, City or Town,	State, Zip C	Code)		
			ubb (Wife)		5350	Wend	dy Ro	ad Syk	esvil	le, M	D 21784	07	- 01-1-1		
	20a. Method of Dispo		Removel from State	C	emetery, cre	metory or	other plea	ce)	De	ete :	20c. Location -	City or Tow	m, State		
	4 Donetion	5 ☐ Other (Specify	Lake View Mer			em. E	n. Park 8,		22/98 Sykesville, M			MD			
DUCE	21. Signature of Fun	neral Service Licen	22. Neme end Address of Fecility HAIGHT FUNERAL HOME & CHAPEL (Box 195 Sykesville, MD 21784 (410)-795-1400							x 195)				
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State of Maryland / Department of Health and Mental Hygiene

						C	ertificate	of L	Death			Reg. No.	W ()	-	100	and,
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Exam		4e. Facility Nema (If not institution, give street and number) 4b. City, Town, or L										County of De				
		Residence: 13 Norman Allan Road Elkto									on			Cecil		
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ath v	rai	13 Norman Allan Road 21921										U.S				
72 hours efter death with the Maryland natural, or Items 23a or 28a-f show 3cal Examiner must be nothed at	Funeral	11. Marital Status 12. Wes Decedent Ever in U,S Armed Forces? 1 ☐ Never Married 2 ☐ Married 12. Wes Decedent Ever in U,S Armed Forces? 1 ☐ Yes, Give				U,S. 13. Was Decedent of Hispanic Origin? (Spett Yas, specify Cuban, Mexican, Puerto					ecify Yas or No- Rican, atc.) 14. Rece- Black,			American Indian, White, etc.		
rs eff	by F	3 Widowed 4		1□ Yes 2	XNo	Specify:				Specify:	Whi	te				
hour	8	****				16a. Decedent's Usuel Occupetion (Give kind of work done during most of work						16h Kin	d of Business			
in 72	Completed	15. Decedent's Education (Specify only highest grade completed)				(Gli	ve kind of work . DO NOT use	done d	lu <i>ring mo</i> si)	t of workir	ng	TOD. KIII	d of Busines	sariidus	ıry	
with ena.	mo	Nine Yea	Homemaker					Personal				sidenc	9			
Hyg Hyg ent,	BeC	17. Fathar's Name (First, Middla, Last) 18. Mother's						r's Neme	(First, Middle			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	-			
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shound M	-	19e. Informent's Name						Street a	and Numbe	-				, Zip Co	ide)	
permit. Peges 1 end 2 should be filed within 72 hours efter death with the Manylan Department of Heelth end Mantal Hyglena. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other treumatic event, the Medical Examinator man be nothed at once.		Eileen C.	Gibson	(daugh	ter)	13 N	13 Norman Allan Road,			id, E	lkton,	Mary	aryland 21921			
f Hee		20a. Method of Disposit		20b. Piece of Disposi							Dete			or Town, Stete		
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arth orta		21. Signature of Funerel Service Licensee 22. Name end Address of Fecility							V					Tuna		
Depa Impo any i		Lee A. Patterson & Son Funeral Home														
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law requires that the as been signed by th 2 Should be detache	hy										1 ☐ Yes 2 ☐ No 3 ☐ Probe				y 4 ZU	nknown
gned be de	by I															
v require been si									24a. Wes en eutopsy performed?			24b. Were eutopsy findings available prior to				
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0 - 0	Completed										10	Yes 2K	No	1 🗆 Y	es 2□N	ło
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or Attending Physician: thar deeth. Director: After this certific in by the funeral director,		27. Manner of Death		28a. Date	of tnjury	28b. Time	of 280	c. Injury Work			28d. Describe			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
oth. r: Aft	Certification:	1 Naturel 5 2 Accident	☐ Pending Investigetion		nth, Day Year,	injury	М		r res 2□1	No						
or Attendi aftar deeth Director: A	lific		Could not be determined	200. FIEU	e of injury - Al	home, farm,	street, factory, o	office		2	8f. Location		Number or	Rural R	oute Numbe	er,
s afte	Seri	4 Hollicide	4 ☐ Homicide building, etc. (Specify) City or Town, State)													
Hospital or Attending I 24 hours aftar deeth. Funeral Director: After staly filled in by the funer		29a. Certifier 1X	Certifying Pt	ystofan: To the	best of my k	nowledge, de	eth occurred et	the tim	e, date en	d plece, e	nd due to the	ceuse(s)	end menner	es stete	d.	
To the Hospital or Attending Physician: within 24 hours after deeth. To the Funeral Director: After this certificial compiataly filled in by the funeral director.	edical	(Check only 2 one)	medical Exai	niner: On the b	easis of exami ner stated.	netion end/or	investigetion, in	n my op	oinion, deel	tn occurre	ea et the time,	dete end	piece, end d	ue to the	e ceuse(s)	
Withi To th	×	29b. Signeture end title	of cartifier				29c. l	License	number			29d. Dete	signed (Mo	nth, Day	y, Year)	
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decadant's Nama (First, Middla, Lest) 2 Date of Death 3. Time of Daath **Physician** Augth22, 17:11 Charles Clayton Hixson /Medical 4e. Fecility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Memorial Hospital Cumberland Allegany 5. Social Security Number Sex 4€ M 2□ F if Undar 1 Yaar | If Undar 24 Hrs. 8. Data of Birth Month, Pay Year 1965 7. Aga (In yrs. last birthday) Funeral 9. Birthplaca (Stata or Foreign Days GOWIN'S 219-96-3127 33 Yrs. Director Usual Rasidance of Dacedant Pages 1 and 2 should be filed within 72 hours efter death with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits ms 23e or 28e-f show Allegany Cumberland YE Yes 2 No Director 10a. Straat and Numbar 10f. Zip Coda 10g. Citizen of What Country? 1323 Virginia Avenue USA 21502 Funeral items 2 12. Was Dacedant Evar in U,S. Armad Forees? 1 ☐ Yes 至 No If Yas, Giva Yaar or Datas: Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxicen, Puarto Rican, atc.) Race - Amaricen Indian, Bieck, Whita, etc. the Medical Examiner Navar Married 2 Married 1 Yas Z No 21215-0020 6 Specify: Be Completed by 3 Widowed 4 Divorced white "natural" 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 15. Dacadant's Education (Specify only highast grade complated) 16b. Kind of Business/Industry Hygiene. College (1-4or 5+) Elamentary/Secondary (0-12) Employee Newspaper traumatic event, altimore, Maryland 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumema) ound be the state of the state Richard E. Hixson Juanita (Thomas) 19a. informant's Name/Ralationship (Typa, Print) 19b. Mailing Address (Straat and Numbar or Rural Route Number, City or Town, Stete, Zip Coda) nt of Health e 1323 Virginia Avenue Cumberland MD 21502 Juanita J. Hixson-mother other 20a. Mathod of Disposition
1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 20b. Place of Disposition (Nema of cemetery, cramatory or other placa)

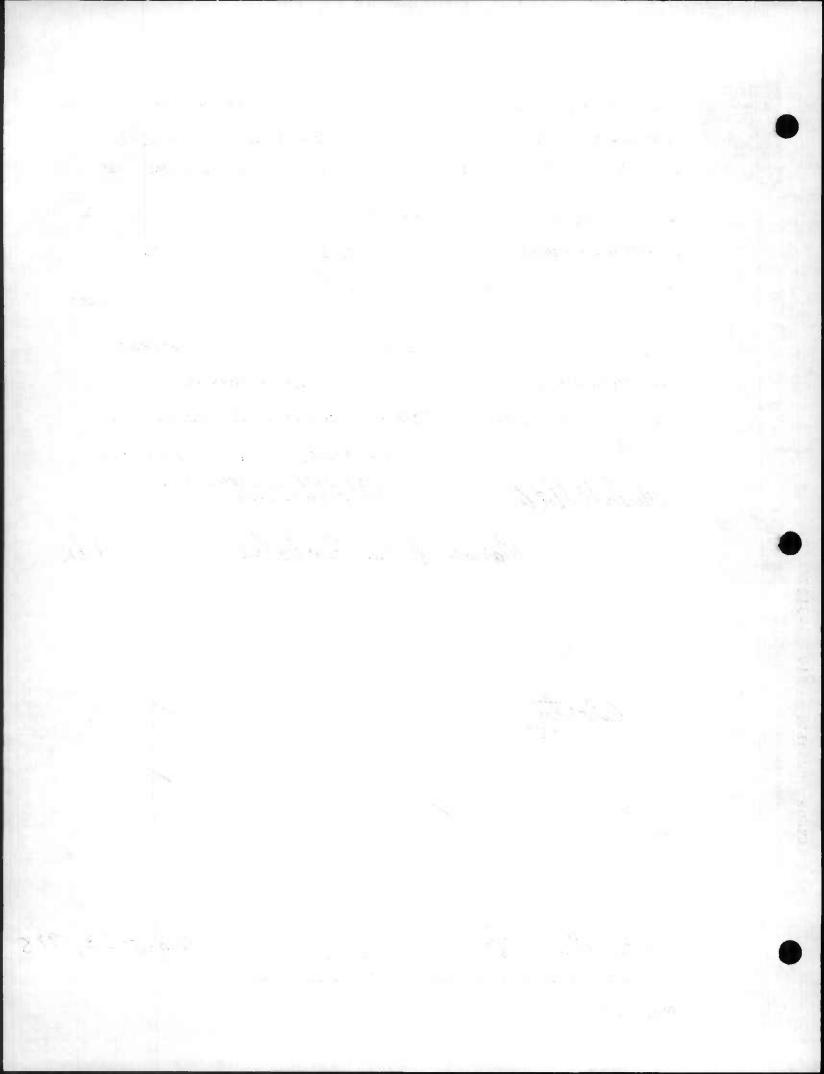
Cumberland Crematory 20c. Location - City or Town, Stata 0 Department of Important: If any injury or once. 08/23 Cumberland MD 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatura of Funara/Sarvice License 22. Name and Address of Facility P.A. Scarpelli Funeral Home, P.A. Cumberland MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intarval Between Physician /Medical immedieta Cause (Final disaasa or condition resulting in death) Examiner Examiner The law requires that the death certificete be executed Sequantially list conditions, if eny, laading to immadiata ceusa. Enter Undarlying Causa (Diseasa or injury that initiated avants rasulting in death) Lest Due to (or as a consequence of): physician Physician/Medical Dua to (or as a consaquance of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. the 23b. Did tobacco use contribute to the cause of death? o signed by 1 Yas 2 No 3 Probably 4 Unknown 0 g 99 24b. Wara eutopsy findings available prior to completion of ceusa of death? pege 2 should Completed 24a. Was en autopsy pertormad? been certificate has 1 ☐ Yas 2 ☐ No Division of Vital or Attending Physicien: Be 25. Was cesa raferred to madical 26. Placa of Death (Chack only ona) Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) Certification: To 1 Yas 2 No 1 Inpatiant 2 ER/Outpatiant 3 DOA this funeral 27. Manner of Death 28d. Dascribe how injury occurred 28e. Data of Injury (Month, Day Yaar) 28b. Tima of 28c. Injury at Work? After 1 Natural 5 Panding invastigation hours after deeth. 1 ☐ Yas 2 ☐ No 2 Accidant the 6 Could not be determined 3 Suicida 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify) in by 4 Homicida To the Hospital or within 24 hours aft To the Funerel Di completely filled in 1 Certifying Physician: To the best of my knowledge, deeth occurred et tha tima, data and place, end due to the ceuse(s) and manner es steted.
2 Madical Examiner: On the basis of examinetion and/or invastigetion, in my opinion, deeth occurred et the tima, data and place, and due to the causa(s) end mannar statad. 29a. Cartifian Medical 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifia 29c. License number 8 D28910 30. Nama and addrass of parson who completed causa of daath (Item 23e) (Type, Print) 500 Memorial Avenue Cumberland MD 21502 Dr. H. Curtis Merrick 31. Data tilad (Month, Day, Yaer) 32. Ragistrar's Signature State AUG 2 4 1998 Registrar

DHMH 16 Rev 6/95

219-96-3127

CHARLES

HIXSON.



Amended # 26, Nols, Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 8/18/98, Allegany Country State of Maryland / Department of Health and Mental Hygiene 98 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** Month Aug 18, 1998 2:30 a.m. Georgie Marie Harvey /Medical 4e. Fecility Neme (If not Institution, give street end number) 4h. Cltv. Town, or Location of Deeth 4c. County of Deeth **Examiner** 229 Baltimore Avenue Apt. 409 Cumberland
If Under 1 Year | If Under 24 Hrs. | 8 Allegany 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Dev. Year) 1□ M 2X F Months Deys Hours Yrs. Director 213-22-4035 MD Mar 9, 1925 Usuel Residence of Deceden deeth with the Maryland 10e. Stete 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 1 Yes 2 No MD Allegany Cumberland 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 229 Baltimore Avenue Apt. 409 Funeral 21502 USA items 2 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Raca - American Indian, Bleck, White, etc. 7 is marked other than "natural", or iten traumatic event, use Wedical Examinat Pages 1 end 2 should be filed within 72 hours aftar 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Merried 21215-0020 1 ☐ Yes 2 ☑ No Specify: þ 3 ₩ Widowed 4 Divorced Specify: white Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuei Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be is marked of George Trennum Bertha (Beck) 19e. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health as Important: If Item 27 is any Injury or other trau Margaret Lapp-daughter Baltimore, 1611 Frederick Street Cumberland MD 21502 20e. Method of Disposition 20b. Piece of Disposition (Name of cometery, cremetory or other piece) Dete 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Hillcrest Memorial Park | 08/20 Cumberland MD 21. Signature of Fuperal Se 22. Name end Address of Fecility Scarpelli Funeral Home, P.A. Cumberland MD 21502 ations that caused the death. So not enter the mode of dying, such as cardiac or respiretory errest, Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Final IA disease or condition resulting in deeth) **Examiner** Due to (or es e consequenca of): The law requires that the deeth certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Couse (Diseese or injury that initiated events resulting in death) Lest Due to (or es e consequence of): Division of Vital Records. P.O. Box 68760. physician Physician/Medical the Due to (or es e consequence of): Pert II. Other significent conditione contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? as been signed by 2 should be detac 1 Yes 2 No 3 Probably Munknown þ Completed 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? certificata 1 ☐ Yes 20 No 1 ☐ Yes 2 ☐ No Attending Physicien: Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Hospital: 1 Inpatient PER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 2 1 Yes 2 No After this 27, Manner of Deeth 28a. Dete of Injury (Month, Dey Year) 28b. Time of Certification: 28d. Describe how Injury occurred 28c. Injury et Work? 1 Neturel 5 Pending investigation death. 1 Yes 2 No 2 ☐ Accident within 24 hours efter death To the Funeral Director: completely filled in by the 3 Suicide 6 Could not be determined 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 ☐ Homleide 8 Hospital edical 1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es steted.
2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end placa, and due to the ceuse(s) end menner steted. 29a. Certifier (Check only one) the 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 5 D28910

State Registrar

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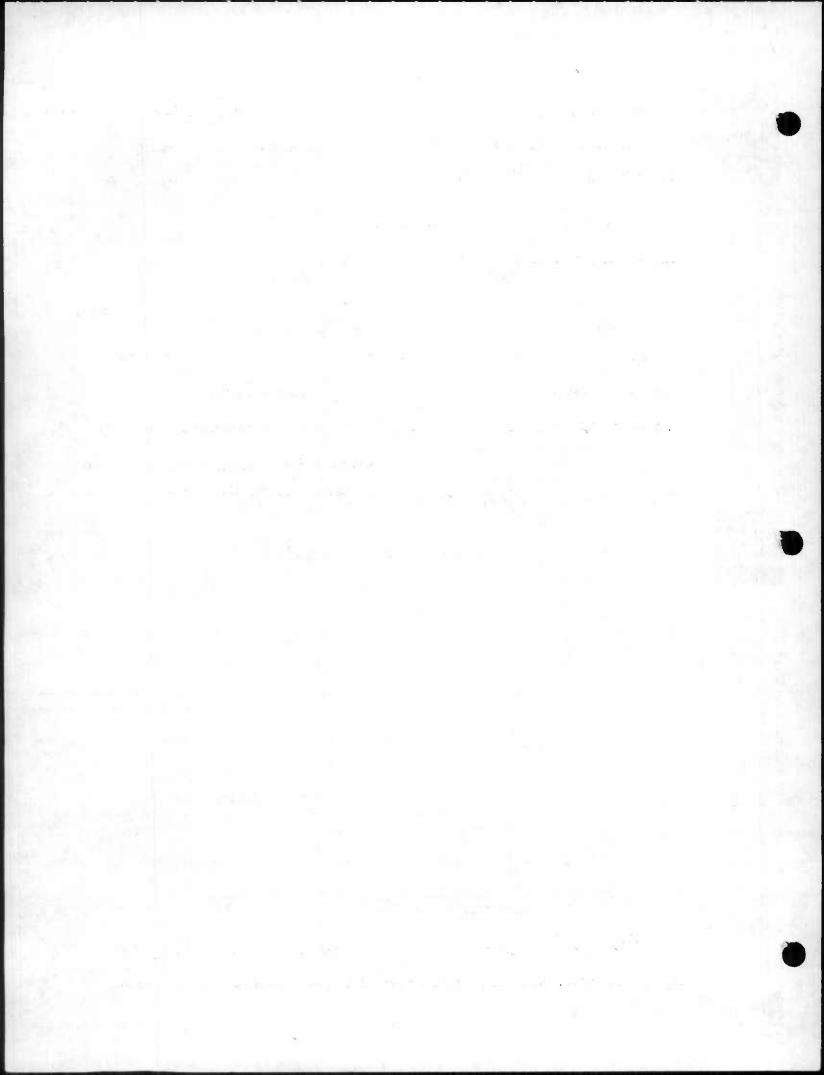
31. Dete filed (Month, Day, Yeer) AUG 1 8 1998

Dr. H. Curtiss Merrick

500 Memorial Ave. Cumberland MD 21502 22. Registrer's Signeture

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

Sporks



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month 1998 3:00 P.M. R. Haines August 4e. Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth 7943 Henslowe Court Pasadena Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Feb. 25,1924 9. Birthpiece (State or Foreign Country)
West Virginia 7. Age (In yrs. lest birthdey) 1□M XXF 74 Yrs. Feb. 10b. County 10c. City. Town or Location 10d. inside City Limits Anne Arundel Pasadena 1 ☐ Yes 2 ☐No 10f. Zip Code 10g. Citizen of Whet Country? 7943 Henslowe Court 21122 U.S.A. 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes ≥ 2 ②No If Yes, Give Yeer or Dates: Race - American Indien, Bleck, White, etc. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Never Merried 2 Merried 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuei Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Electronics Assembler Computer Industry 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Sumeme) Walter D. Howdyshell Ruth G. Cunningham 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Thomas P. Haines/Son 7943 Henslowe Court Pasadena, MD 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State Aug. 11 4 ☐ Donetion 5 ☐ Other (Specify) Queens Point Cemetery 1998 Keyser, WV 21. Signeture of Funeral Service Licansee 22. Name end Address of Fecility Rotruck-Smith Funeral Home rean Z 85 S. Main Street Keyser, WV 26726 23a. Part 1. Enter the disease, or compilections that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart failure. List only one cause on each line. Approximete intervei Between Onset end Deeth SY Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? 1) Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings evelleble prior to completion of cause of deeth? 24a. Wes en eutopsy 2 No 2)(No 1 Yes 1 Tes 26. Piece of Death (Check only one)

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Salvasion Dupaya Ramirez,

Physician /Medical **Examiner**

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signed by t

page 2 s

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To the Hospital or Attending Physician: "Within 24 hours efter death.

Jo the Funeral Director: After this cartifica complataly filled in by the funeral director; p

usa as

The law requires that the death certificate be axecuted

Box 68760,

P.O. I

Records,

Division of Vital

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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"naturel", or Items 23a

permit. Pages 1 and 2 should be illed within 72 hours effer of Department of Health and Mental Hygiene. Important: if item 27 is marked other than "nature!", or ites any injury or other traumatic event, the Medical Events and page.

Baltimore, Maryland 21215-0020

the Medical Examiner must be notified at

Director

Funeral

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Completed

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Janet

5. Sociel Security Number

236-36-1606

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Maryland

11. Meritei Status

10e. Street end Number

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20a. Method of Disposition

Immediete Ceuse (Final

Usuei Residence of Decedent

Examiner Physician/Medical À Be Completed Certification: To

disease or condition resulting in death) Sequentielly list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Part il. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 25. Wes case referred to medical exeminer? Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1□ Yes 2 No 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Netural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) Piece of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piace, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination end/or investigetion, in my opinion, death occurred at the time, date and piace, and due to the cause(s) and menner steted. 29a. Certifier 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year)

Smite 204

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Frint)

Highway

32. Registrar's Signature

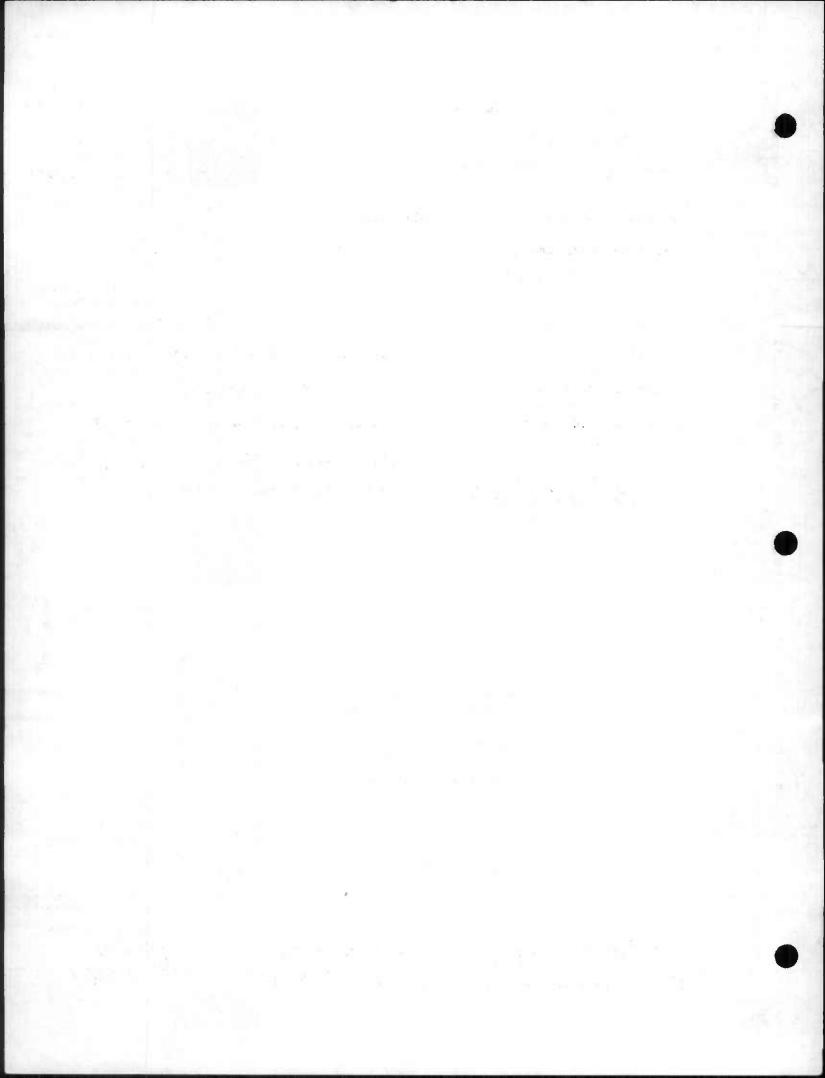
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State Registrar

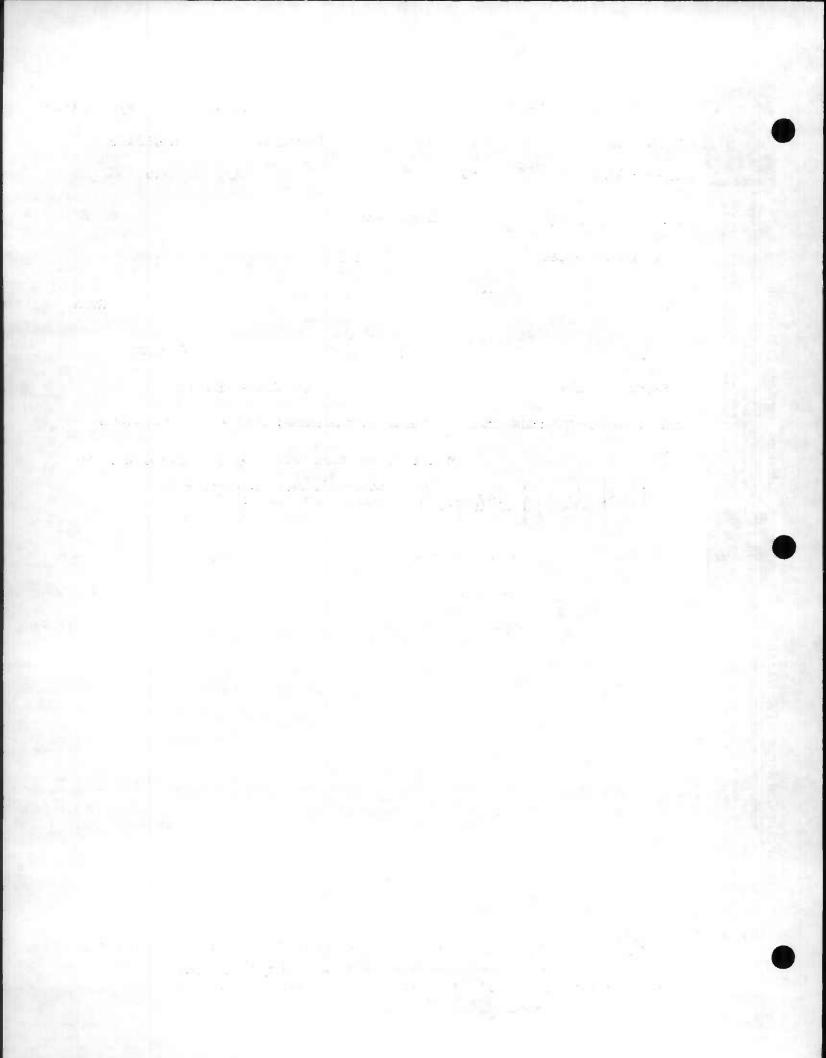
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- /Medic Examin		4a Facility Nama (If not institution, give	re street and number)				4	4b. City, Tov		cation of Death	4c. County			
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ate be axecuted hysician and the burial-transit	Ca	that initiated events	c. AORTIC		TENOS r as a conseq								7 years	-
ng phy as th	Ped	resulting in death) Last										i		
ath cert	any		d				-							
. 5 . 5	Physician/Medi	Part II. Other significant conditions of	ontributing to death bu	it not res	ulting In the ur	nderlying	cause giv	ven in Part I.		23b. Dld t	obacco use co	ontribute t	o the cause of death	n?
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OVISION OF VICES or Attending Physician: The state death. Illector: After this certificate in by the funeral director, pe	- T	1 ☐ Yes 2 ☒ No 27. Manner of Death	1 A Inpatie	_	ER/Outpatien		UA	4LI NU		me 5 Resid			(y)	_
After fune	tol	1 Natural 5 ☐ Pending	(Month, Day	Year)	Injury	м	28c. Injur Wor 1 □	rk? Yes 2⊡I						
deat deat ctor: y tha	Certification:	3 ☐ Suicide 6 ☐ Could not b	e Dines of Injur	ıry - At h	ome, farm, str	aet, factor	y, office					ber or Run	al Routa Number,	
d in b	Full	4 Homicide	building, etc	. (Specif	y)					City or Tow	n, State)			
To the Hospital or Attending Physician: The is within 24 burus after death. To the Funeral Director: After this certificate ha completely filled in by the tuneral director, page.	edical C	29a. Certifier (Check only one)	ysician: To the best of miner: On the basis of and manner sta	examine	wledge, death tion end/or inv	occurred vestigation	at the tir	me, date an opinion, dee	d place, th occur	and due to the dred et the time, d	euse(s) end m date end plece	anner es s , end due t	stated. o the ceuse(s)	
o the	Me	29b. Signature and title of certifiar				29	c. Licens	se number			29d. Date sign	ed (Month,	Day, Year)	
- 5 - 0		Ronna m.	EURANIII	m.D		A	524	10232	1 DE	9007	AUGUST	8 th	1998	
12	-	30. Neme and eddress of person who	completed cause of de	eath (Iten	n 23a) (Type.								. 1 10	
mJ		2401 W. BELVEDERE		-	LTIMOP	E	MAR	RYLAN	UD	evers/e	3			
Sta	te	31. Data filed (Month, Day, Yaar)	32. Registra	r's Signa	itura R									
Registr	ar	AUG 1 1	1998	Lavior	WWW.	COLL,								

DHMH 16 Rav 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death Year Month **Physician** August FRANK 1312 HOBBS 15 1978 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WICOMICO SALISBURY PENINSULA REGIONAL MEDICAL CENTER Birthplaca (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 XM 2 □ F Director 213-24-4417 September 26,1929 Maryland Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland Directo Wicomico Salisbury 288-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 flame 23a 8189 Brown Road 21804 USA Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 12. Was Decedant Evar in U,S. Armed Forces? 11. Marital Status Black, White, etc. 1 ⊠Yes 2 □ No
If Yes, Give
Yeer or Detes: Navy 1 ☐ Never Merried 2 ☑ Married Baltimore, Maryland 21215-0020 'natural', or 1 Yes 2 No Specify: Specity: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) Collega (1-4or 5+) Assistant Manager Beverage Retail 12 17. Fathar's Neme (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fit ment of Health and Mental H tent; if Nem 27 is tranked off Be Frank Milby Hobbs Olive Andrews 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any injury or other tra Eileen Hobbs/Wife 8189 Brown Rd., Salisbury, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete Maryland Veterans Cemetery 8/19/98 Hurlock, MD 4 ☐ Donetion 5 ☐ Other (Specify) um of Economic Service Licens 22. Nama end Address of Fecility Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21804.

In Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory errest, Applications. Approximete Intervel Between Onset and Death Physician acute Myocar Immediate Cause (Finel disease or condition resulting in deeth) /Medical Examiner Examiner Oles Cru physician and the burial-transit Sequentielly list conditions, if eny, leading to immadiate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in deeth) Lest Due to (or as a consequence of) Physician/Medical Dua to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24a. Wes an autopsy performed? 24b. Were autopsy findings aveilable prior to Completed completion of cause of death? 20 No 1 ☐ Yes 2 ☐ No 1 Yes Division of Vital or Attending Physician: 25. Wes case referred to medical axaminer? 26. Place of Death (Check only one) Certification: To Be Hospitel: 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) 28c. Injury at Work? 27. Manner of Death 28b. Time of / 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 1 Natural 2 Accident 5 Pending To the Hospital or Attending within 24 hours efter death.
To the Funeral Director: Afte completely filled in by the fun 1 Yes 2 No Investigation 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide edical Certifier (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated.

Medical Examinar: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and title of continue presenter, M. D A 29105 30. Name and address of person who completed causa of death (Item 23a) (Type, Print) 106 MILFORD ST., SAUSBURY, MD. 21801 CHRISTJON J. HUDDIESTON, MD

DHMH 16 Rav 6/95

State

Registrar

31. Date filed (Month, Day, Year)

AUG 1 9 1998

HOBBS

FRANK

32. Registrer's Signeture

State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Daeth 3. Time of Deeth Month **Physician** 15 4:00 pm 1998 RUTH August EVERLEY /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street and number) 4c. County of Death **Examiner** Wicomico Nursing Home Wicomico Salisbury If Under 24 Hrs. 5. Sociel Security Number If Under 1 Year 7. Age (In yrs. lest birthdey) Birthplece (Stete or Foreign Country) 8. Date of Birth (Month, Dey, Year) **Funeral** 1□ M 20 F Months Deys Hours Yrs. 496-26-5293 Director October 28,1916 Illinois Usual Residence of Deceden the Maryland 10c. City, Town or Location 10a Stete 10h Counts 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f shor traumstic event, the Madical Examinar must be notified at 1 ☐ Yes 2 No Maryland Wicomico Salisbury Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 900 Booth Street 21801 USA Funerai 12. Wes Decedent Ever in U,S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Yeer or Dates: WW T Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, 11. Maritel Stetus Bleck, White, etc. 1 Never Merried 2 ☐ Married Maryland 21215-0020 1 Yes 2 No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced WW II 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT usa ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Foreign Mission Board College (1-4or 5+) Elementery/Secondary (0-12) Southern Baptist Conv Missionary Nurse 12 4+ 18. Mother's Name (First, Middla, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Pages 1 and 2 should be 1 nent of Health and Mental I Wallace Rutherford Hayes Ruth Rebecca Jockisch 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Raletionship (Type, Print) Eunice H. Ruark/Sister 306 Andover Dr., Salisbury, MD 21804 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremetion 3 ☐ Removal from State Salisbury Crematory 9/17/98 4 ☐ Donetion 5 ☐ Othar (Specify) Salisbury, MD 22. Name and Address of Fecility Euperal Service Licenses Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21804 cf or complications they caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, Applications on each line. Approximeta Intervel Batween Onset end Death **Physician** framediate Cause (Finel disease or condition resulting in deeth) Terumal Promosin. /Medical Examiner Due to (or es e consequence of): Examiner physician and the burial-transit Sequentielly list conditions, if eny, laeding to immadiata cause. Entar Undarlying Cause (Diseasa or Injury that initiated events resulting in death) Lest 'NSOlin Dependent Physician/Medicai Due to (or es e consequence of): signed by the a Pert II. Other significent conditione contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Dfd tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Coloney arting Distase þ 24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? 24a. Was an eutopsy Sciqures. 1 ☐ Yes 2 No Mentally lacompetent-1 ☐ Yes 2 ☐ No or Attending Physician: aftar death. Director: Aftar this certific 25. Wes cese referred to medical exeminer? 26. Place of Death (Check only ona) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28e. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of 1 Neturel 5 Panding 1 Yes 2 No investigation 2 Accident 6 Could not be datarmined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) A 24 house the Funeral Director of the filled in by 4 Homicida Hospital 24 hours a XX Certifying Physician: To the bast of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

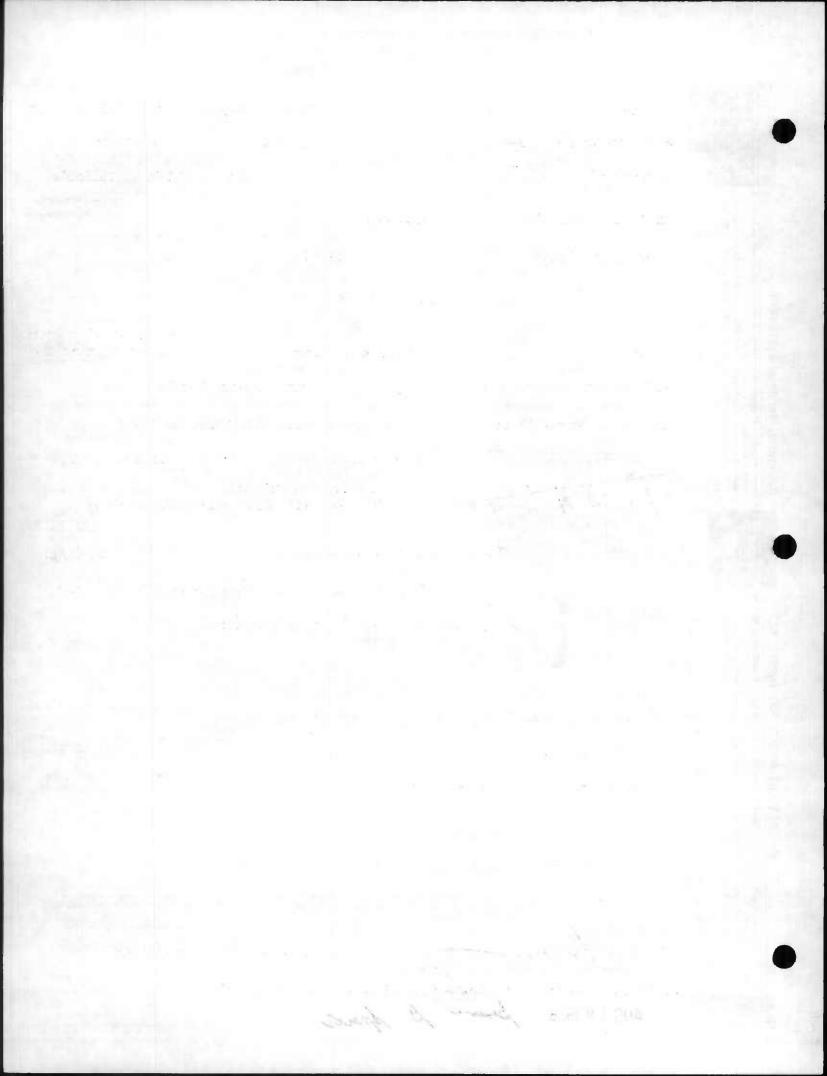
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. To the Hospi within 24 hou To the Funer completaly fill 29a. Cartifier edicai (Check only one) 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signeture end title of certifie D02026

Division of Vital Records, P.O. Box 68760

State Registrar Federico G. Arthes, AUG 1 9 1998

30. Name end eddress of person who complated cause of death (Item 23e) (Type, Print)

MD 1622A Ocean Pines Berlin, MD 21811



State of Maryland / Department of Health and Mental Hygiene

ene 98 2740

					, , , , , , , , , , , , , , , , , , , ,		rtificate of			Reg. No.	0 4	7401
	Physic	an	Decedent's Name (First, Midd				IIo	41-	2. Date of D Month	eath Dey	Year	3. Time of Death
	/Medi		George	ELLSWO			неа	th ,SR.	Augus	t 19, 19	98	3:55 PM
	Exami	ner	4a. Fecility Name (If not institution Salisbury Cent	. 0	,	erCare		Salisbu	or Location of Dea CY, MD		of Death	
	Funeral Director		5. Social Security Number 216-36-0247	6. Sax 1 X M 2□ F	7. Aga (In yrs. 51	. last birthday) 8 Yrs.	If Undar 1 Yaar Months Days		n. (Month, D	irth ay, Year) 31,1939	9. Birthplac Country MARY	ce (State or Foreign LAND
	and		Usual Residence of Decedent 10a. State 10b. Count	/	10c. Ci	ity, Town or Lo	ocation				100	I. Inside City Limits
	Maryl feho	lor	MD WIG	COMICO			SALISB	IIDV				1 X Yes 2 □ No
	r 28a	Director	10e. Street end Number	Onico			10f. Zip Code	UKI		10g. Citizen of	What Country	/?
	h wit	al D	321 POPI	AR HILL A	VE.			21801		IJ	.S.A.	
20	72 hours after death with the Maryland neture!', or items 23e or 28a-f ehow osel Examinat must be notified at	by Funeral	11. Maritai Status 1 Never Married 2 Mar 3 Widowed 4 X Divorce	12. Was Dec Armed F rried 1 Yes	cedent Ever in Lorces? 2 X No ive		Was Decadent of If Yas, specify Cub 1 ☐ Yes 2 💢 No	Hispanic Origin? oan, Mexican, Pu	(Spacify Yes or N erto Rican, etc.)		ce - American ck, White, etc	0.
9	"netural", or	ed b		nt's Education	Dates:	16a Dece	dent's Usual Occu	nation	-v	16b. Kind of B	WHIT	
215-0020		Completed	(Specify only higher Etementary/Secondery (0-12)	st grade completed,		(Give	kind of work done DO NOT use retire	during most of w	rorking	TOD. KING OF B	dali losa/i lou.	otry
212	filed within Hygiene. ther than ent, ne we	Com	8	College	(1-4or 5+)		LABOR	ER		CONST	TRUCTION	ON CO.
pu	0 = 0 \$	Be C	17. Fathar's Nama (First, Middle	, Last)				18. Mother's N	ame (First, Middle	e, Maiden Suman	ne)	
Maryland		2	CLAYTO	N		HEATH		MAD	ELINE		Z	EPP
Mar	2 4 4 5		19a. Informant's Name/Relation				ng Address (Stree			ber, City or Town,	, State, Zip C	ode)
	C = 0 -		MANDY L. HEATH	GIBB - D			64 MORRI	S MILL R	T	ALISBURY		
lor	r in		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 Removal from		cemetery, crer	sition (Neme of netory or other pla	ace)	Dete	20c. Location	- City or Town	n, State
altimore,	permit. Pag Department Important: If eny injury o		4 Donation 5 Other (S	Specify)			E CREMATO		8-21-98	CAMBRI	DGE, N	<u>1</u> D
Bal	Depariment Department Important Irriginal Irri		21. Signature of Funeral Service	Licensee	1 -	22	2. Name and Addr	ess of Facility		705 I	E. MAII	N ST.
	Physician /Medical Examiner		23a. Part1. Enter the disaase, o shock, or heert felture. Lis Immediate Cause (Final disease or condition resulting in death)	r complications that t only one ceuse on a.	dausad tha dea		lan		ac or respiratory	arrest,	A CO	MD 21804 pproximete alterval Between onset and Death
Т	ted nsit	n lu		bCE	apen	la	- 61	al	far	lan	4.	107.
	be executed sician and buriel-transit	Examiner	Sequentially list conditions, if any, laading to immediate	1	Due to	or as a consec	juenca of):					
x 68760,	tificate ig phys	ledical	Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. <i>C.</i> d.	Dua to (c	or as a consaq	uance of):	ور			9	u-T.
Box	attendin	Physician/N										
	that the de led by the a detached	ysic	Part II. Other significant conditi	ons contributing to d	leath but not res	sulting In the u	nderiying cause g	iven in Pert I.				he causa of death
P.O.	that the by deta		Somor	1 cm					1	Yes 2 No	3 Proba	bly 4 📉 Unknow
Records,	sw requires s been sign 2 should be	Completed by	Dirlete	7					24e. Wa	s an autopsy ormed?	availe	a autopsy findings able prior to oletion of cause ath?
R	The law sete has page 2	Com							1 🗆	Yes 2X No	10	ras 2□ No
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of V	0 0	2	1 Yes 2 No	Hospital: 1 🗆	Inpatient 2	ER/Outpetier	nt 3□ DOA O	her: 4 Nursing	Home 5 ☐ Res	sidenca 6 □Ott	ner (Specify)	
Division o	ath. r: After	Certification:	E C 7 TOOTGETT	igation	of Injury oth, Day Year)	28b. Time of Injury	Wo	ork?] Yas 2 □ No	28d. Describe	how injury occur	rred	
Divi	To the Hospital or Atte within 24 hours efter de To the Funeral Directo completely filled in by th	Certifi	4 Homicide determ	nined 286. Plac build	ling, etc. (Speci	(fy)	eet, factory, office		City or To	(Street and Numi own, State)		
	n 24 hot ne Funel bletely fil	edical	29a. Cartifier 12 Certifyli (Check only one) 12 Medical	ng Physician: To the Examiner: On the b end man	e best of my kno pasis of examine oner stated.	owledge, death etion and/or in	n occurred at the t vestigation, in my	ime, date and pta opinion, death oc	ce, and due to the curred at the time	ceuse(s) end m , date and place,	anner es stet and dua to th	ed. ne causa(s)
	within To th	M	29b. Signature and title of certifie	71 /	2		29c. Licen	se number		29d. Date signe	ed (Month, De	ay, Year)
	,		1/1/9	THE			D 29	349		8/201	98	
	/		30. Name and address of person							11	. 0	
	9		William H. Rol	oins, M.D.	. 1104	Health	way Dr.,	Salisbu	ary, MD	21804		

DHMH 16 Rav 6/95

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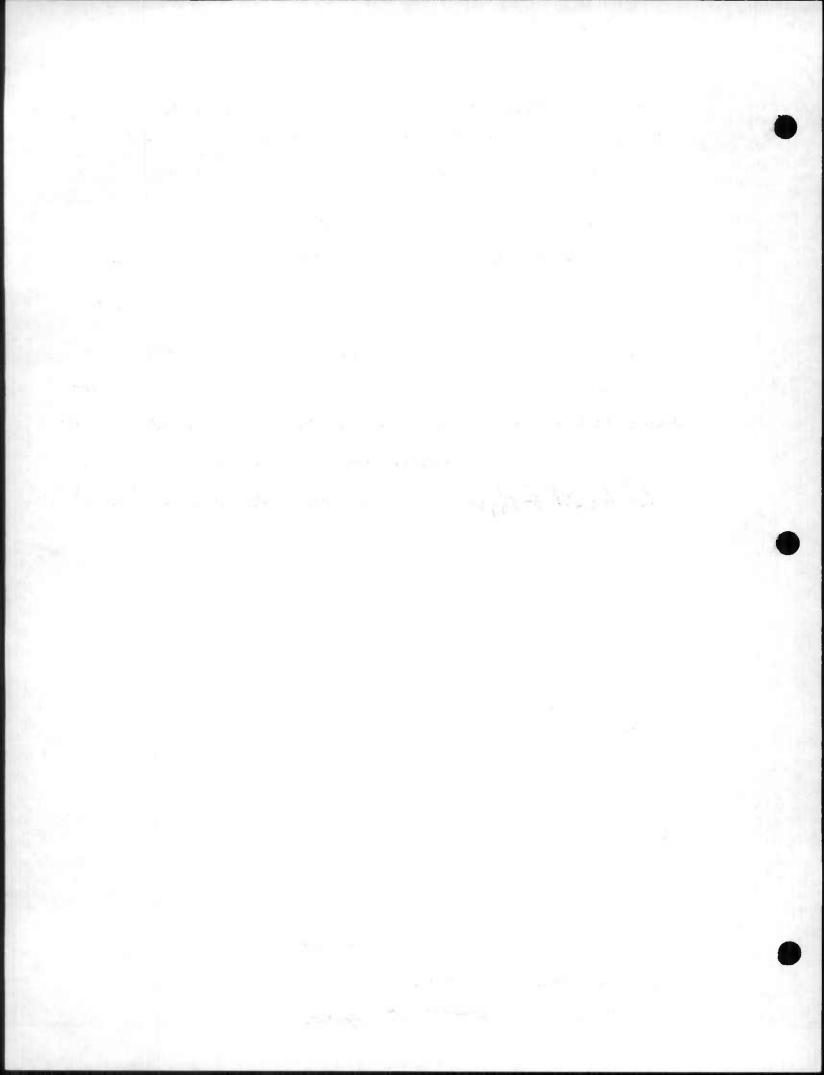
Registrar

31. Date filed (Month, Day, Yeer)

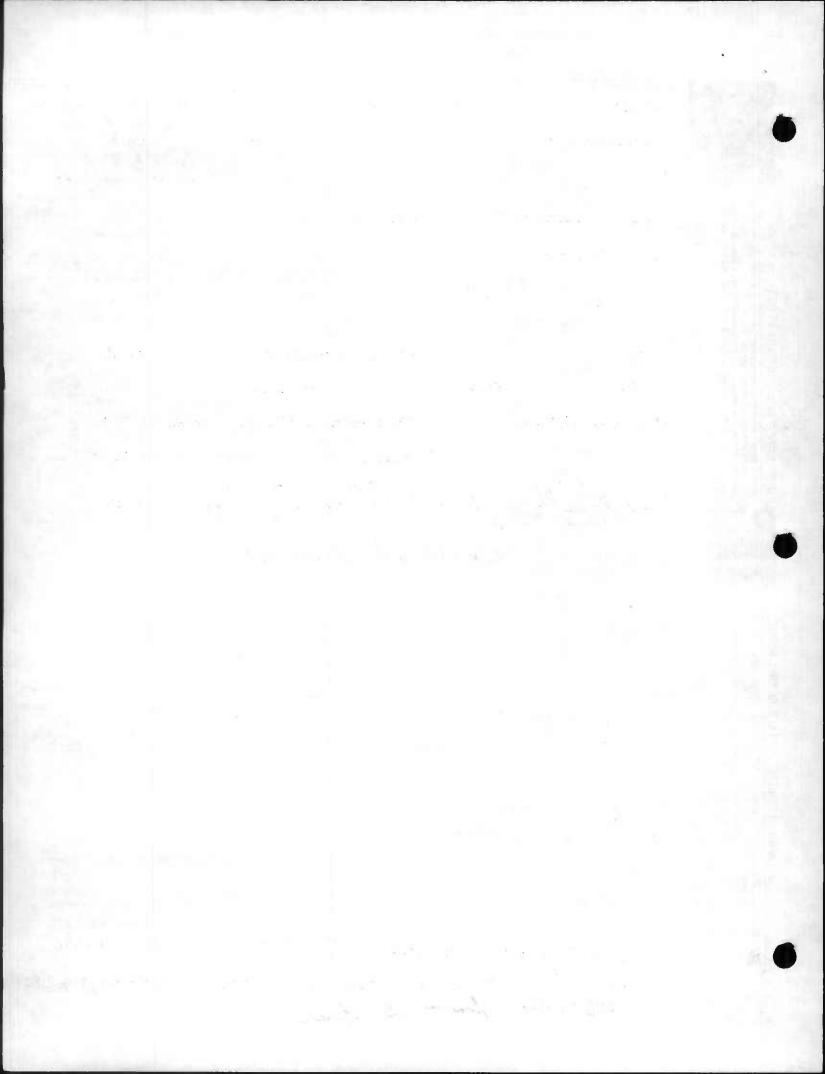
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32. Registrar's Signature

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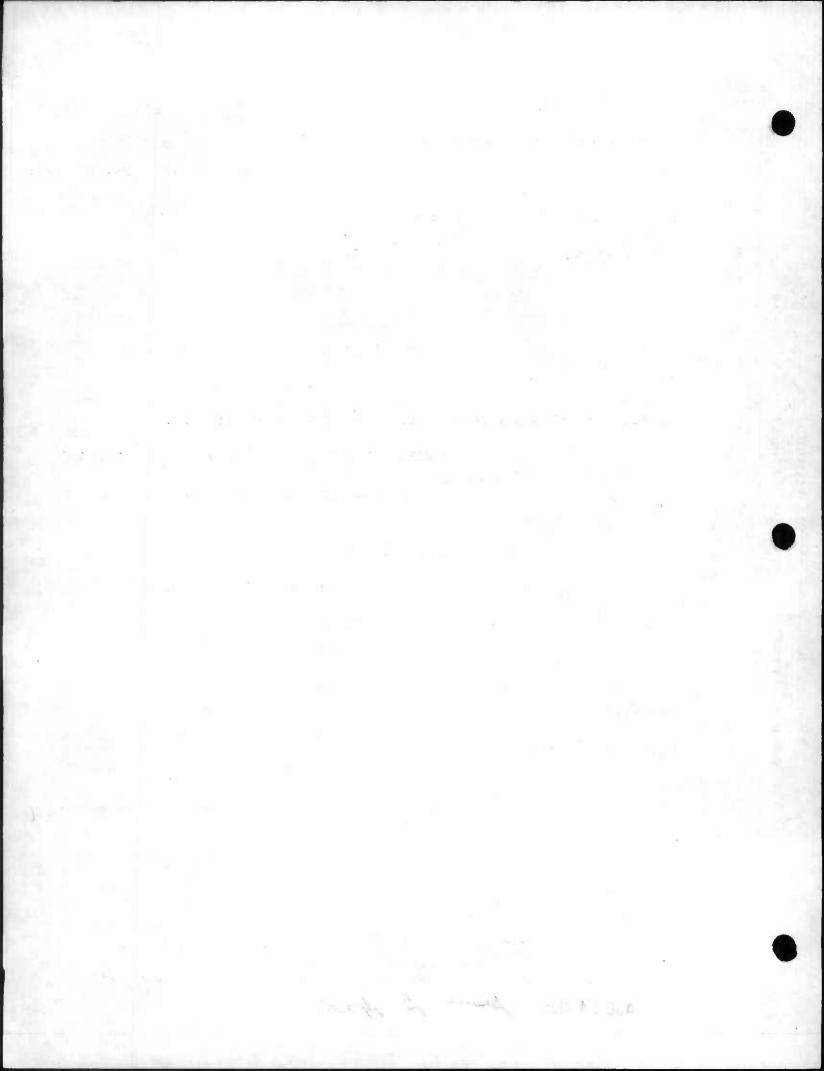
	1. Decedent's Name	First, Middle, Las	em 8 cl	le	C	ertificate o	Death	2. Date of Dea	leg. No.		3. Time of Death
ian	WILLIA			EDWAR	D	HAIG		Month		Year 8	12:50 AM
cal ner	4a Facility Name (If	not institution, give					4b. City, Town, or	Location of Daath			
-	205 Bro	oklyn Ave	9				Salsil	oury	Wicon		
	5. Social Sacurity Nu		1.0	7. Age (In	yrs. last birthda	Months Day	r if Under 24 Hrs	8. Date of Birth (Month, De)	Year)1957	9. Birthpla	ace (Stete or Fore
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	Usuel Residence of 10a. State	Decedent 10b. County		100	c. City, Town or	Location				10	d. insida City Lim
	Maryland	Wicon	nico			sbury					1 ∑ Yas 2 🗆 I
	10e. Street and Num				Dull	10f. Zip Code			10g. Citizen of W	/hat Count	IV?
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	11. Manital Status	7	12. Was Deci	edant Evar	in U,S. 1		f Hispanic Origin? (Suban, Maxican, Pue	Specify Yas or No-		- Amarica	
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	17. Father's Name (i			- i -				ma (First, Middla,	MEIGER SUMEME	e)	
	William			aig	461.15	Nine A 43 49	Marjorie		Cib T-	Ctota 7'-	Codo
	19a. Informent's Ne						etend Number or R				
	Kristine 20a. Method of Disp	Haig/Sis	scer	21	Ob. Place of Dis	sposition (Nema of	m Hills I	Date Date	20c. Location - (
	1 Burlal 2 □	☐ Cremation 3 ☐			cametery, c	rematory or other p		8/31/98			
	4 ☐ Donetion 21. Signature of Fur	5 Other (Specify			HILLCIG	est Cemet	-	0/31/90	Annapol	1.15,	כווא
	23a. Panti. Enter the shock, or heart limmediata Cause (F diseasa or condition rasulting in daath)	Final				enter tha mode of d	W Hill Rd lylng, such es cardie	., Salish	oury, MD rest,		Approximate interval Between
	Immediata Cause (F	Final nditions, mediata trying njury		Due		501 Snoventer tha mode of december that mode	WHill Rd	., Salish	oury, MD rest,		Approximate interval Between
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	1. Decedent's Nama (First, Middle, Las	st)				2. Data of Deat		3. Tima of Death
hysician	WILLIAM JO	OSHUA	HUDSON	TR.		August	2-	8 1905
/Medical xaminer	4a Facility Nama (If not institution, give		HODDON	o k.	4b. City, Town, or L	1	4c. County of E	
xammer	PENINSULA REGION		CENTED		SALISBU			OMICO
	5. Social Security Number 6. So		In yrs. last birth	(av) If Under 1 Year		R Date of Birth		
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THE A	10a. Stata 10b. County	1	Oc. City, Town	or Location				10d. Inside City Limit
be notified	DELAWARE SUSSEX		SELBYVI	1				
D P	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wha	t Country?
out le	R.D. 2, BOX 82A			19975			USA	
Examiner must be notified at by Funeral Director	11. Maritel Status 1 X Never Merried 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forcas? 1 Yas 2 XNo If Yas, Giva Yaer or Datas:	er in U,S.	 Wes Decedent of I If Yas, specify Cub Yas 2 X No 		pecify Yes or No- p Rican, atc.)		American Indian, White, etc.
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o Be	WILLIAM J. HUDSON				DELORES			
To To	19a. Informant's Name/Ralationship (Type, WILLIAM J. HUDSON S		10h 1	Mailing Addrass (Street				ta Zin Code!
T I				Total Commercial				
	20a. Method of Disposition	N SK./FAIRE		. 2, BOX 8	ZA, SELBI		ELAWAKE 20c. Location - City	19975
6 6	1 🖾 Burial 2 🗆 Cramation 3 🗆	Ramovel from Stata	camatary,	crematory or other pla	11111			
5	4 Donation 5 Othar (Specify		ROXAN	A CEMETERY	8	/25/98	ROXANA, 1	DELAWARE
any injury or once.	21. Signaturi of Funeral Service Licen	Hox -	-	22. Nama end Addra HASTINGS F		ME, SELB	YVILLE, I	DE. 19975
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ician dical niner	Immediate Cause (Final disaasa or condition rasulting in daath)	. Cardio	genic	Shock				1
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william Hudson

1091-ch-166



State of Maryland / Depart

rtment of Health and M	ental Hygiene	27401
tificate of Death	Reg. No.	

			Cer	tificate of	Death	F	leg. No.		
	1. Decedent's Name (First, Middle, Las	et)				2. Dete of Dea			Time of Death
Physician (Modical	HERBERT BRUC	E HOLLA	ND			AUGUST		rear 8	1432PM
/Medical Examiner	4a Facility Neme (If not institution, give	street and number)			4b. City, Town, or	Location of Deeth		-	
	PENINSULA REGIONA	L HOSPITAL E	R.R.		SALISBU	RY	WICOMI	CO COI	JNTY
Funeral Director	5. Social Security Number 6. Se		rrs. lest birthday) Yrs.	If Under 1 Year Months Deys		1. (Month, Dey	Year) 1954 M	9. Birthplace Country) ARYLAN	(State or Foreign
pue *	10e. Stata 10b. County	10c.	City, Town or Loc	ation				10d. I	nside City Limits
Marylend F show	DELAWARE SUSSEX	g	ELBYVILL	F				1	☐ Yes 2 No
the Mi	10e. Street and Number		DDDI VIDD	10f. Zip Code			log. Citizan of Wh	nat Country?	
23a or	201 STONEY RUN WE	ST		19975			USA		
tar des	11. Marital Status 1 X Never Married 2 ☐ Married	12. Wes Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	lf.	as Decedent of	oan, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		American in White, etc.	
d within 72 hours el giene. or than "natural", or the Medical Exam completed by I	15. Decedent's Ed	ucetion	16a. Decade	ant's Usual Occu	pation		16b. Kind of Busi		
ed within 72 ho ygiene. Ner than "naturn nt, the Medical	(Specify only highest grade Elemantary/Secondary (0-12)	de completed) College (1-4or 5+)	(Give k	kind of work done O NOT use retire	during most of world)	orking			
d within jiene. r than the Ma	12	College (19401 54)	MANAGE	R			RESTAUR	ANT	
	17. Father's Name (First, Middle, Last)				18. Mother's Na	ame (First, Middle,	Maidan Sumame))	
d 2 should be file th and Mentat Hy 7 is marked othe traumatic event	HERBERT HOLLAND				BETTY JA	ANE SLAYS	MAN		
d 2 should the and Ment 7 is marked traumatic	19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailin	g Address (Stree	t and Number or F	Rural Route Numbe	r, City or Town, S	tate, Zip Coo	le)
	HERBERT HOLLAND/F	ATHER	184 W	EST PON	D CIRCLE	, SELBYVI	LLE, DE.	199	75
8 5 2 0	20a. Method of Disposition		b. Plece of Dispos cemetery, crem	sition (Name of satory or other pla	ace)	Date	20c. Location - C	ity or Town,	State
pemit. Pages Department of I Important: If its any injury or or once.	1 ☐ Burial 2 X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		ALISBURY	CREMAT	ORY	8/24/98	SALISBUR	Y, MAI	RYLAND
Physician /Medical Examiner	23a. Paint. Enter the disease, or comp shock, or haart failure. List only of Immediate Cause (Final disease or condition resulting in deeth)	olications that cause defined on a cause on each line.	Eath. Do not ente			HOME, SEL ac or respiratory an		App	L 9975 proximete proxit Between set and Death
lasth certificate be executed attending physician end for use as the burial-transit clear/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or Injury that initiated events resulting in death) Lest	c	o (or as a consequ o (or es e consequ					1	
the atter the atter thed for u	Part II. Other eignificant conditions co	ontributing to death but not	rasulting in the un	darlying causa g	iven in Part I.	23b. Dld t	obacco usa cont	ribute to the	cause of death
es that the death igned by the atte be datached for by Physicia						101	/es 2□No 3	3 Probabl	4 Unknow
requir been s should						24e. Was a		availab	utopsy findings le prior to tion of cause h?
The law ate has page 2						100	es 2□No	24 Ye	s 2 No
sician: The certificate irector, page Co	25. Was case raferred to medical				26. Placa of D	aath (Check only o	na)		
Physician: this certific ral director,	examiner? 1 🔀 Yes 2 🗆 No	Hospital: 1 ☐ Inpatient 2	ER/Outpatient	3 DOA	ther: 4 Nursing	Home 5 ☐ Resid	lenca 6 Other	(Specify)	
After this funeral di	27. Manner of Death	28a. Date of Injury (Month, Dey Year	28b. Tima of Injury	28c. Inju	ury at	28d. Dascribe h	low Injury occurred	d	· I word
	1 Natural 5 Panding 2 Accident Investigation	8/15/98	130 1 1		Yes 2 No	and	Huch	Culi	rit
After or de by tiffic	3 Sulcide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spe	At home, farm, stre	et, factory, office		28f. Location (S City or Tow	Street and Number	or Rural Ro	ute Number
Cer in Oct in Cer			L	vedera	7	20 and.	54 Selly	ville L	Ielawa
To the Hospital or Attantition within 24 hours after deat to the Funeral Director: completaly filled in by the Medical Certifical	29a. Certifier 1 ☐ Certifying Phyone) 2 ☑ Medical Exem	ysician: To the best of my liner: On the basts of exam and manner stated.	knowledge, death ination and/or inv	occurred at the tastigation, in my	ime, date and place optnton, daath occ	ce, and due to the courred at the tima, o	cause(s) and man data and place, ar	nar as stated nd due to the	i. cause(s)
To the vithing To the comp	29b. Signature and the of certifiar	1 Kings	20		c.M.E.		29d. Date signed AUGUST 2		
3	30. Name and address of person who of	complated causa of down (Print)		ltimore.			

State Registrar 31. Data filad (Month, Day, Year) 32. Registrar's Signature

AUG 2 4 1998

& Sparky

7 (A) (A) (A) (A) (A) (A) (A) Military San San San ART OF THE STATE O There is a second of the secon

Physician /Medical Examiner physician and s the buriel-transit The law requires that the death certificete be executed

the Maryland

death

filed within 72 hours efter

Baltimore, Maryland 21215-0020

28a-f show

6 items 23a

"natural", or

I Hygiene.

marked other

d for use es t the signed by the Completed certificate hes t Be 2 Certification: To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in but at a

Division of Vital Records, P.O. Box 68760,

Physician:

director

this funeral

After Attending

24b. Ware autopsy findings aveliable prior to completion of cause of death? 24a. Was an autopsy performed? 2 NAO 1 ☐ Yes 1 ☐ Yas 2 ☐ No

25. Was casa raferred to medical examinar? 26. Place of Death (Check only one) 1 Yas 2 Othar: 4 Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □Other (Specify) 27. Manner of Death 28d. Describe how Injury occurred 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work?

Natural 5 Panding 1 Yes 2 No investigetion 2 Accidant 3 Suicide 6 Could not be 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rurel Route Number, City or Town, Stata) 4 Homicide

29a. Certifier 1) Certifying Phyelcian: To the best of my knowledge, death occurred at the time, data end placa, and due to the cause(s) and manner as stated.

2 Uedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at tha tima, date and place, and due to the cause(s) and manner enter.

29b. Signature and title of conflict 29c. License number 29d. Date signed (Morth, Day, Year)

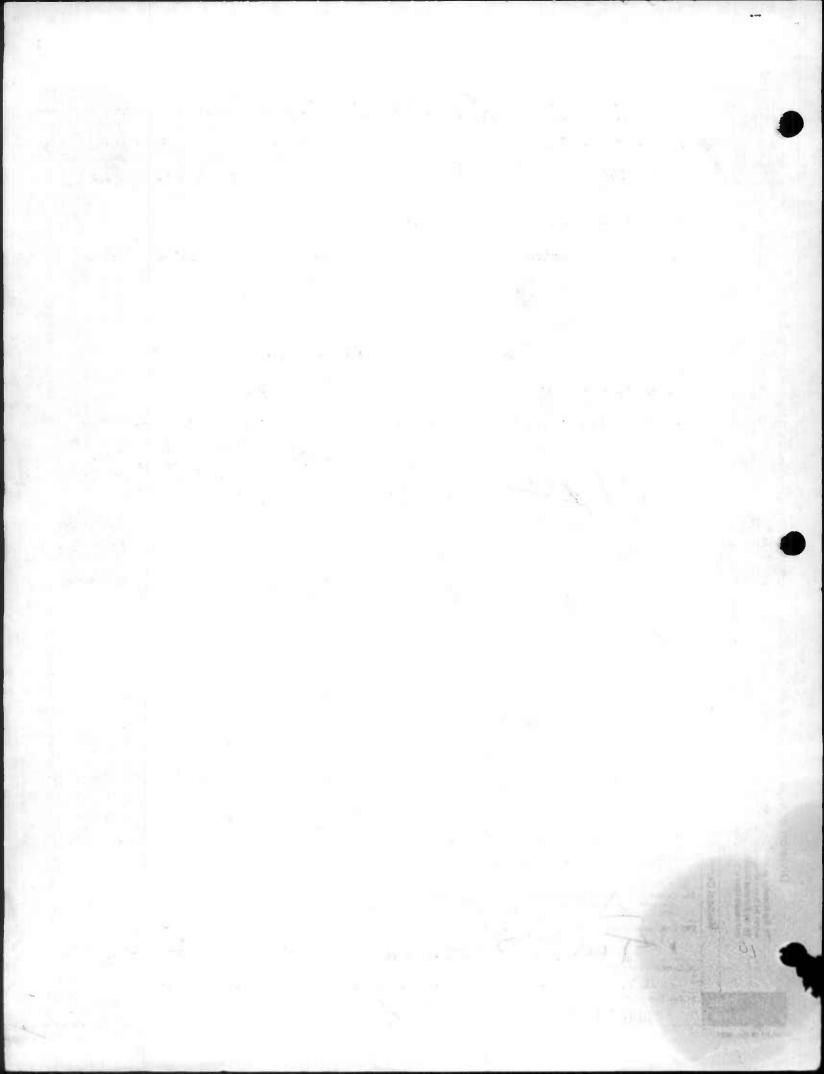
M400 30. Name and addrass of person who completed cause of death (Itam 23a) (Type, Print)

Paul T. Noone, M.D. 50 W. Edmonstone Drive, #207, Rockville, Maryland

31. Data filed (Month, Day, Year) State AUG 2 4 1998 32/Registrar's Signature

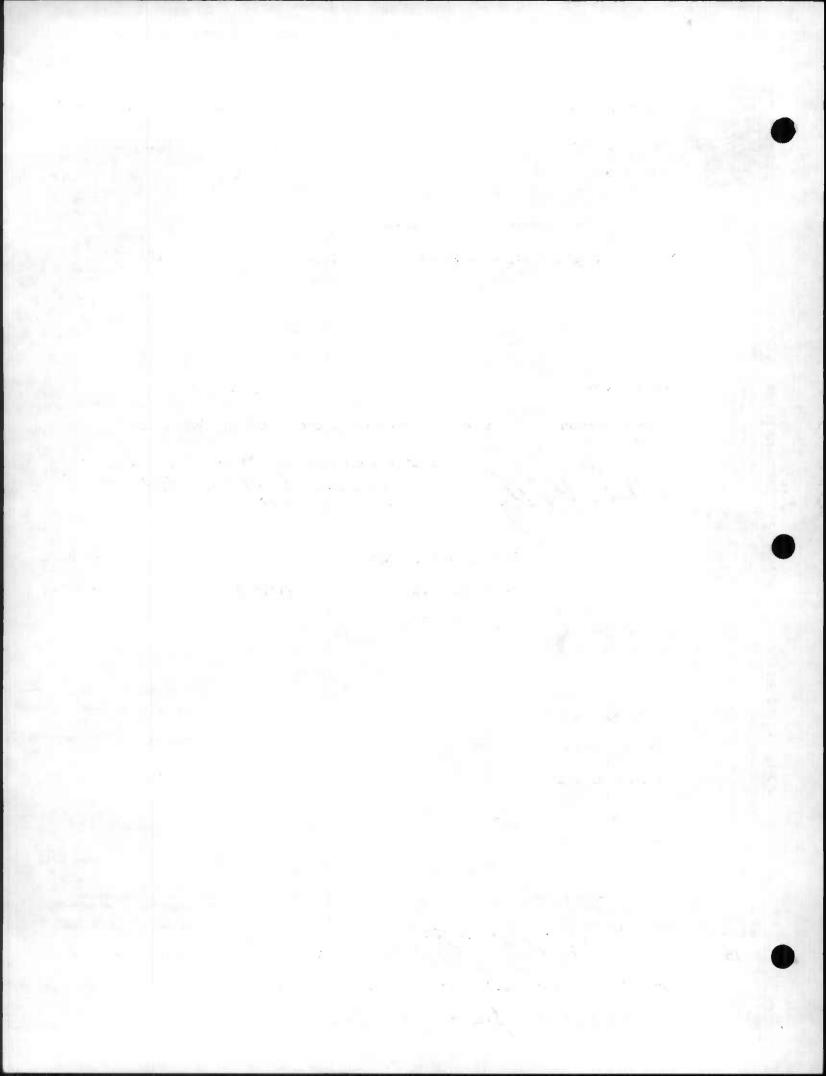
Medical

10



	1. Decedant's Nam	a (First, Middla,	Last)				tificate				2. Data of De			3. Tim	e of Death
	Robert	J. Herzo	g							A	Month	23, 199	Year 8	06	1.5
	4e Facility Neme (number)	75			-	4b. City, To		ation of Deetl		of Death	1	
	Suburba	an Hospi	tal						В	ethes	da	Monte	omer	v	
	5. Social Security N		. Sax	_		t birthdey)	If Undar Months	Yaar Deys	If Undar Hours		8. Date of Bir (Month, De				ta or Foraign
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	MD														as 2 No
	10e. Street and Nu		gomery		Be	thesda	10f. Zip	Coda				10g. Citizen of V	Vhat Count	trv?	
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			d												
F	Part II. Othar elgni	ficant conditions	contributing to	o daath but r	not rasulti	ing In the ur	ndarlying ca	usa giv	an in Part	1.	23b. Did	tobacco uae co	ntributa to	the cau	ee of death
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	Malnut	rition									24a. Was	an autopsy ormed?	COI	mplation	osy findings rior to of cause
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,	Cancer	of col	on								1 🗆	Yes 2 No	10	Yas	2 No
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	2 ☐ Accident 3 ☐ Suicide	Invastigat	ha -	lace of Injury	v - At hom	a farm str			743 2		8f, Location /	Street and Numb	er or Rura	/ Route	Number.
	4 Homicida	datarmine	bi bi	lace of Injury uilding, atc. ((Specify)	m, rattii, 3(1)	and rectory	, omoa		-		wn, Stata)			
	29a. Cartifiar (Check only											causa(s) and mi			sea(a)
	one)	∠⊔ Madical Ex		a basis of an		n and/or inv	astigation,	ın my c	pinion, da	BILL OCCULLE	u at tha tima,	data and place,	and dua to	INA CAL	58(5)
	29b. Signatura and	titla of centifiar	1/	11	0	X	290	Licens	se number			29d. Data signe	d (Month,	Dey, Ye	ar)
		In	3/0	de	8-	1		D1	1921			August	25. 1	1998	
1	30. Nama and add	1./										0			
-	John Ga	lotto, 1	4.D., 5	225 P	ooks	Hill	Road	Be	these	ła, M	208	14			
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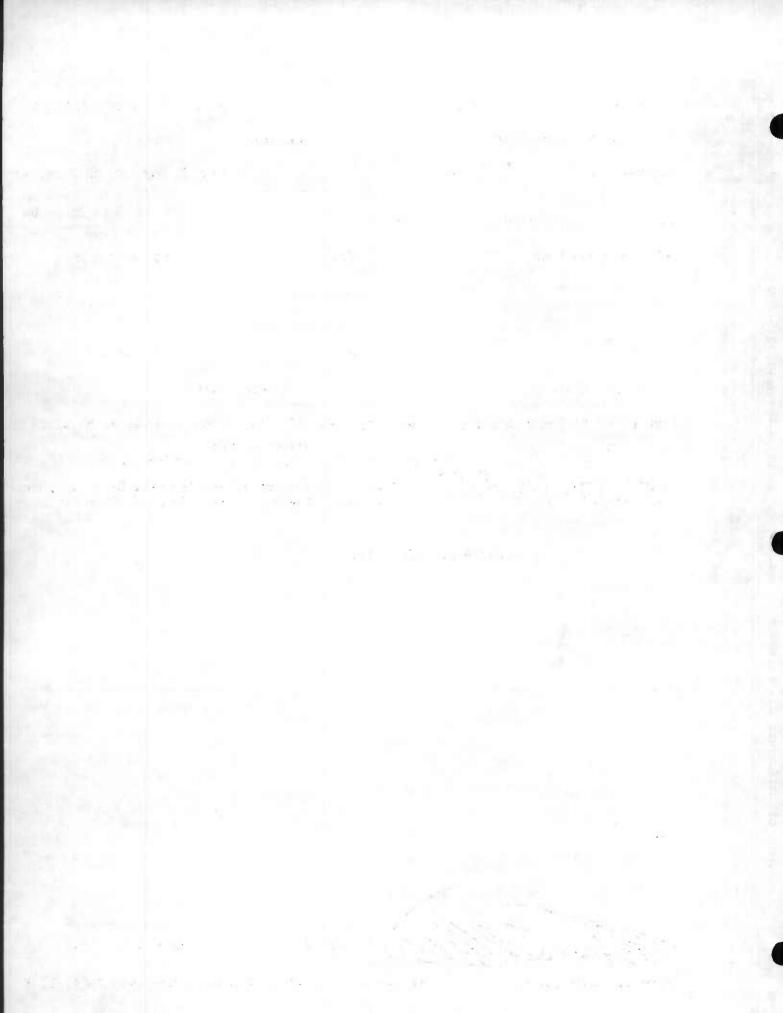
DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

					Certifica	te of	Death	F	leg. No.	Ö	2/4	07
		1. Decedent's Name (First, Middle, Las	ot)	Table .				2. Date of Dae Month	th Day	Year	3. Time	of Death
П	Physician /Medical	Laurene H.	He	оу				August		1998	9:00) AM
	Examiner	4a Fecility Neme (If not institution, give	street and number)				4b. City, Town, or	Location of Death	4c. County	of Death		
		4909 Hampden Lan	e, #202				Bethesd		Montg	omer	y	
	Funeral Director	5. Social Security Number 361-05-8654 Usual Residence of Decedent	ex 7. Ag □ M 2⊠ F	e (In yrs. last bi	Yrs. If Und Month	er 1 Year s Days		8. Date of Birth (Month, Day February		Coun	ntry)	e or Foreign rolina
	land m	10a. State 10b. County		10c. City, Tov	vn or Location					1	0d. inside	City Limits
	Many H sh	Maryland Montg	omerv	В	ethesda						1 🗆 Ye	es 2 No
	r 28s	10e. Street and Number	J			ip Code			10g. Citizen of	What Cour	ntry?	
	th will	4909 Hampden Lar	ne, #202			2081	4		Unite	d Sta	tes	
Maryland 21215-0020	be filed within 72 hours after deeth with the Maryland stel Hygiene. d other than "natural", or items 23s or 28s-f show avent, the Medical Escriper must be notified at Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 1 1 Yes, Give Yeer or Detes:		13. Was Dec	-	Hispanic Origin? (S ban, Mexican, Puart Specify:	pecify Yes or No- lo Rican, etc.)	14. Red Bla Specif			
0-10	to within 72 hours ygiene. The Medical It. In Medical Completed	15. Decedent's Ed	ucation	168	Decadent's Us	ual Occu	ipation	delac	16b. Kind of B			
21	within 7	(Specify only highest gra	College (1-4or 5	5+)	lifa. DO NOT	usa ratin	during most of world)	King				
21	Hygien ther the mrt, tre	12			Waitre	SS				taura	nt	
and	be filed itel Hygind other avent, the Be Co	17. Father's Name (First, Middle, Last)						me (First, Middle,	Maiden Sumar	ne)		
ž	should be nd Mentel marked o umatic ave	Fornie Hoyle	E D-i-A	10	to the later of the state of	(С4	Lotti	le Hoyle	City on Town	Ctete 7in	Codel	
Ma	d 2 si T is r traur	19a, Informant's Name/Reletionship (7										0050
	1 end Health em 27 other tr	Barbara H. Rickar	1 / daught	OOL Diese	of Dienocition /A	lama of	ional Lan	Data	20c. Location			0852
Baltimore,	semit. Pages 1 end 2 should Department of Health end Men important: If item 27 is marke any injury or other traumatic ance.	1 Burial 2 XCremetion 3 4 Donation 5 Other (Specify					August 2		Dothood	a Ma		L
	Depertment Partment important: any injury page.	21. Signature of Funaral Sarvice Licen		M00831			torium, I	nc.	Bethesd	a, Ma	гута	na
B	Depe impo impo any fi	23a. Part1. Enter the disease, or compensors, or heart failure. List only	illan Laws	unce	Robert 7557 W	A. P	umphrey Fun sin Avenue,	Bethesda,	Marylan	-Chev 1 2081	y Chas 4-350	e, Inc.
	Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	e. Myocaro		farction consaquance o							
68760,	tificete be axecuted g physician end as the bunal-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c		consequence of							
Box 68	eath certifice attanding philoruse as the clan/Med	resulting in death) Last	d									
	death ed for u	Part II. Other significant conditions co	ontributing to death be	ut not resulting	in the underlying	causa g	iven in Part I.	23b. Did 1	obacco use co	ontribute to	o the caus	e of death?
s, P.O.	requires that the death cert een signed by the attending hould be detached for use eted by Physician/M							10	Yes 2□No	3 □ Pro	bebly 4	☑ Unknown
Records	aw requin								an autopsy rmed?	av	ara autops vallable pric empletion o death?	or to
	The tarta has page							101	res 2 No No	1[□ Yas 2	.□ No
Viital	certificata rector, pag	25. Was case referred to medical examiner?	Han-hali			10		ath (Check only o	ne)			
Division of \	ng Phys fter this ineral di on: To	1 ☆ Yes 2 ☐ No 27. Manner of Death 1 ※ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Data of Inju (Month, Da	ent 2 ER/O ry y Year) 28b.	Tima of Injury	28c. Inj		lome 5 PResident 28d. Describe f			(y)	
Divis	its or A is after is Directled in by	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injuding, etc.	ury - At home, f c. (Specify)	arm, street, fact	ory, office		28f. Location (5 City or Tox		ber or Run	al Route N	umber,
	Ne Hospi n 24 hou Ne Funer pletely fill edical	29a. Certifier 1 Certifying Ph. (Check only one) 2 Medical Example 1	ysician: To the bast of liner: On the basis of and manner size	axamination	e, daath occurre	ed at the ton, in my	time, date and place opinion, daath occu	a, and due to that urred at tha tima,	causa(s) and m data and place	annar as s , and dua t	tated. o tha caus	e(s)
	withir comp	29b. Signature and the coefficer	1	111	2	9c. Licer	nse number		29d. Date sign	ed (Month,	Day, Year)
	3	A STORES	CP/1	1/1	8	D070	099		August	22,	1998	
	3	30. Name and addrass of person who	complated cause or o	eath (Item 23a)	(Type, Print)							
		Francis C. Mayle	, M.D.	10215 F	ernwood	Road	1, #301,	Bethesda	, Maryl	and 2	20817	-1106
	State Registrar	31. Data filad (Month, Day, Year)		ar's Signature	4 1		,					

DHMH 16 Rev 6/95



WRC 98-4967-031 DAVID

Please Type or Print in Biack Indelible Ink. Assure Ali Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

29d. Date signed (Month, Dey, Year)

AUGUST 24, 1998

	HAHM				Cer	tificate	of	Death			Reg. No.	6	1400)
	Physician	Decedent's Name (First, Middle, Land VID MV	ounghoon i	I A LIM						Deta of Dee Month		Yeer 8	3. Time of D	
	/Medical Examiner	4e Fecility Neme (If not institution, gi		de la provincia			1	b. City, Tow	1				10.01	
		HOLY CROSS HO	SPITAL					SILVE						
	Funeral Director		Sex 7. A	ga (In yrs. lest 3	birthdey) Yrs.	If Undar 1 Months	Yaar Deys	If Under 2 Hours	Min.	Dete of Birt (Month, De UGUST	h y, Year) 7, 1995		eca (Stete or I y) RYLAND	
	pue *	Usuel Residence of Decedent 10a. Stete 10b. County		10c. City, T	own or Loc	cation						10	d. Inside City	Limits
	fisho fisho	MD HOWA	nn			T CIT	137						1 🗆 Yes 2	
	ifter death with the Mai r thems 23s or 28s-f s the front be incution Funeral Director	10e. Street and Number	ΝD.	EL	LICOI	10f. Zip 0					10g. Citizen of V	Vhet Count	ry?	
	h with	4949 LEE FARM CO	URT				210	143			US	A		
	deet deet	11. Marital Sfetus	12. Wes Decedent	Ever in U,S.	13. V			ispenic Orlg an, Mexican,	in? (Specific	y Yes or No		e - Amarica k, White, e		
Maryland 21215-0020	by Fr.	XXNever Married 2 Married 3 Widowed 4 Divorced	1 Yes 20 If Yes, Give Year or Dates:			□ Yas Ž		Specify:			Specify		ENTAL	
2-0	72 ho	15. Decedent's E (Specify only highast gr	ducation ade completed)	1	6a. Deced	ent's Usuel kind of work	Occup	ation during most	of working		16b. Kind of Bu	siness/Ind	ustry	
2	be filed within 72 hou titel Hygiene. d other than "nature event, the Medical Be Completed	Elementery/Secondary (0-12)	College (1-4or		life. D	OO NOT use	retire	d)				/ -		
9	filed Hygie Hygie ant, tr	N/A 17. Fether's Neme (First, Middle, Las	t)			N	I/A	18. Mother	's Neme (F	irst, Middle,	Meiden Sumen	N/A		
au	Mentel Mentel or street or	DONG WOOK						HY	E SOO	K				
ary	2 should end Mer is merke aumatic	19a. Informent's Name/Relationship	(Type, Print)		19b. Meilin	g Address (Street			-	er, City or Town,	Stete, Zip	Code)	
	end 2 ealth e n 27 is	DONG WOOK HAHM /	FATHER	4	949 I	EE FA	RM	COURT	ELLI	COTT	CITY MD.	210	43	
more,	permit. Pages 1 end Department of Healt Important: If Item 2: eny injury or other: once.	20a. Method of Disposition 1 Surial 2 Cramation 3 [4 Donetion 5 Dther (Speci	☐Ramoval from State		etery, crem	sition (Name netory or oth	ner plac			Date	20c. Location -			
	Physician /Medical Examiner	shock, or heert failure. List only Immediate Cause (Finel disasse or condition resulting in deeth)	a		Do not ente	er the mode	of dyir	ng, such as o	eardiec or re	espiretory a	SILVER S		Approximete Intervel Betwee Onset end De	een eath
	sit ed		b	Due 10 (01 e.	o conseq	adrice ory.								
,0	cete be executed physicien and s the buriel-transit	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury	0	Due to (or es	e conseq	uence of):								
x 68760	M Bee	that initiated events resulting in deeth) Lest	d	Due to (or es	e consequ	uence of):								
Box	et the death cell of the estendir described for use esteched for use Physician/I	Part II. Other significant conditions		buf not rasultin	a In the ur	derlving ca	usa div	en In Part I.		23b. Dld	tobacco use co	ntribute to	the causs of	death
P.O.										10	Yes 2 10	3 Prob	ably 4□U	nknow
Records,	aw requi is been s 2 should pleted										en eutopsy omad?	eve	re eutopsy fin ilable prior fo npletion of car leeth?	
	The pege									10	¥as 2□No	*E	Yes 2□ N	10
Vita	Sentific actor	25. Wes case referred to medical exeminer?	Hospital:				0.1	or:		Check only o				
5	hys his	1 No 27. Menner of Deeth	Hospitel: 1 Inpat		Outpetien	t 3□ DOA		4 LI NUI			dence 6 □Oth)	
Division of Vital		1 Neturel 5 Pending Accident investigation	(Month, D	ey Year)	Injury	AM 20	kc. Injui Woi 1 🗌	Yes 2 N	6		SCT DI		EV	
VISI	of Attendi effer deeth Director: A d in by the f	3 Sulcide 6 Could not l	28e. Pieca of in	jury - At home			office		281	Location (Streat end Numb	per or Rural	Route Numb	er,
בֿ	pital or At burs efter d eral Direct filled in by	4 Homicide	Sulding, e	ic. (Specify)	-				-	ORDM	oct batish			OM
	Hospital 24 hours Funeral tely filled		hysician: To the best miner: On the basis of											

Registrar

HDYLYDYL WYS 31. Dete filed (Month, Dey, Year)

Olyv-le

11 Penn Street, Baltimore, Maryland 21201

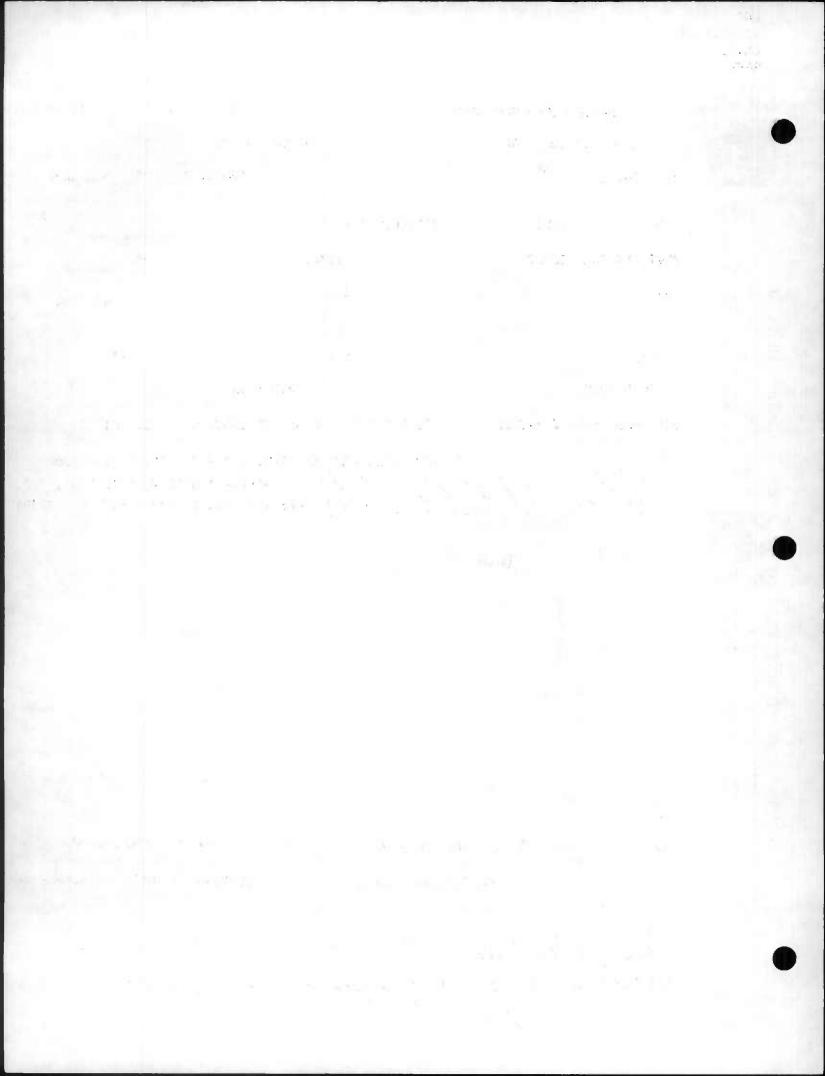
(Or,

29c. License number

O.C.M.E.

AUG 25 1998

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month Yaar **Physician** George William Hallman August 27, 1998 0145 hrs /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner #5 Cecil Manor (At Home) Warwick If Under 1 Year 6. Sex 1∭XM/ 2□ F If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day Year) June 15, 1929 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 69 222-18-7729 Yrs. Director Pernsylvania Usual Residence of Decedent tha Meryland 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yas 2 No Maryland Cecil Director Warwick 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hyglena. Important: If item 27 is marked other than "naturel", or flems 23a any lojury or other traumatic event, the Medical Experiment 2008. # 5 Cecil Manor PO Box 53 21912 Funeral United States 12. Was Decedant Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Nevar Married 2 Married 1 ☐ Yas 2 ☑ No If Yes, Give Yaar or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Painter / Carpenter Home Improvement 17. Father's Nama (First, Middla, Last) 18. Mothar's Name (First, Middla, Malden Sumame) Be William H. Hallman Anna Pearl Ryder 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) # 5 Cecil Manor, PO Box 53, Warwick, Maryland Mrs. Lila L. Hallman 21912 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) August 27, 1998 20c. Location - City or Town, State 4 □ Donation 5 □ Other (Specify Dhesapeake Cremation Center, LLC 21. Signature of Funeral Sarvice Lio Fellows, Helfenbein & Newnam Funeral Home, P.A. William L. King M-00937 226 E. Main Street, PO Box 342, Cecilton, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not antar tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each light. Approximate Intervai Between Physician /Medical Immediate Cause (Final disease or condition resulting in death) Maligment Myoloma 1 yr Examiner Due to (or as a consequence of): Examiner ettending physician and for usa as the burial-transit The law requires that the death cartificata be axecuted Sequentially list conditions, if any, leeding to immediata ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ∑ Unknown þ 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? Completed 1 ☐ Yas 2 ☐ No 1 ☐ Yas 2 ☐ No cartificate or Attending Physician: 25. Wes cese referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home Residence 6 Other (Specify) 2 1 Yas 200 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Aftar this funeral 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28c. tnjury at Work? 28d. Describe how injury occurred Certification: 1) Naturat in 24 hours effer death.
The Funeral Director: Aft 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicida 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29e. Certifier Medical 1 🗘 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, and due to the ceuse(s) and menner es stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, end due to the cause(s) end manner stated. within 2 29b. Signature and title of portific 29c. Licansa number 29d. Data signed (Month, Day, Year) C10000 2768 6 erson who completed ceuse of death (Item 23a) (Type, Print) Dr. M. Hosford, Christiana Medical Center, Suite 116, Christiana, Delaware 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 16 Rev 6/95

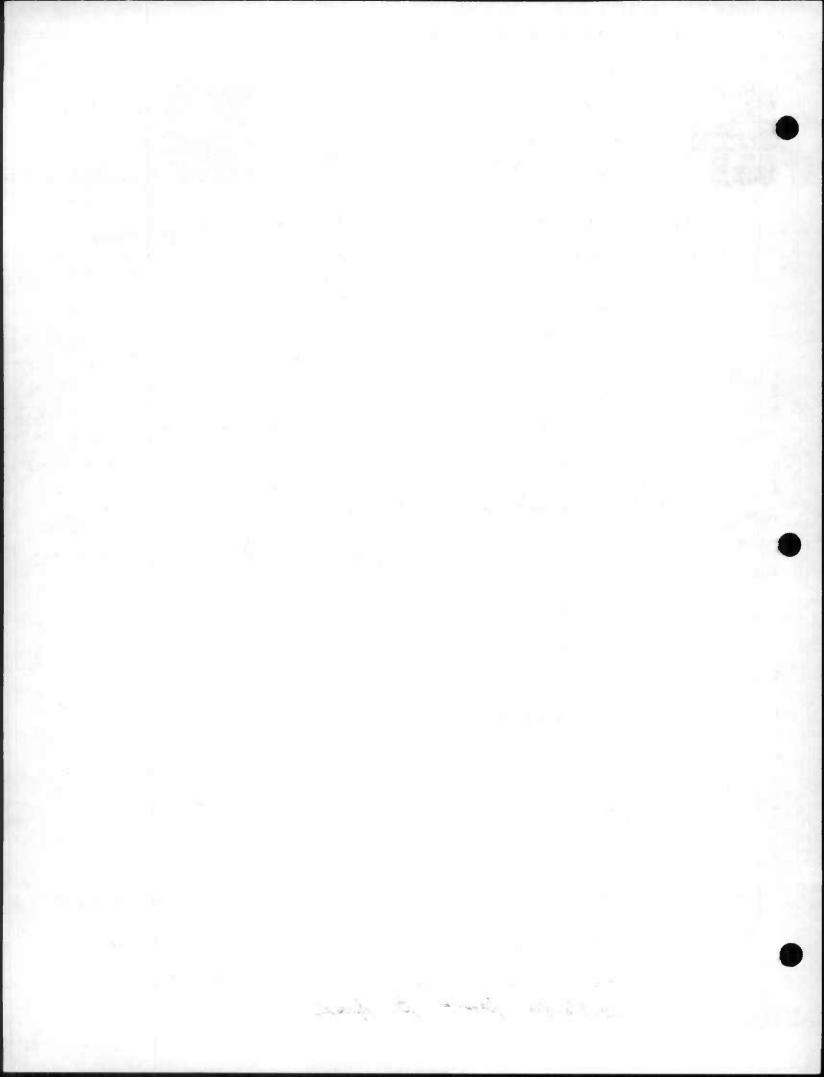
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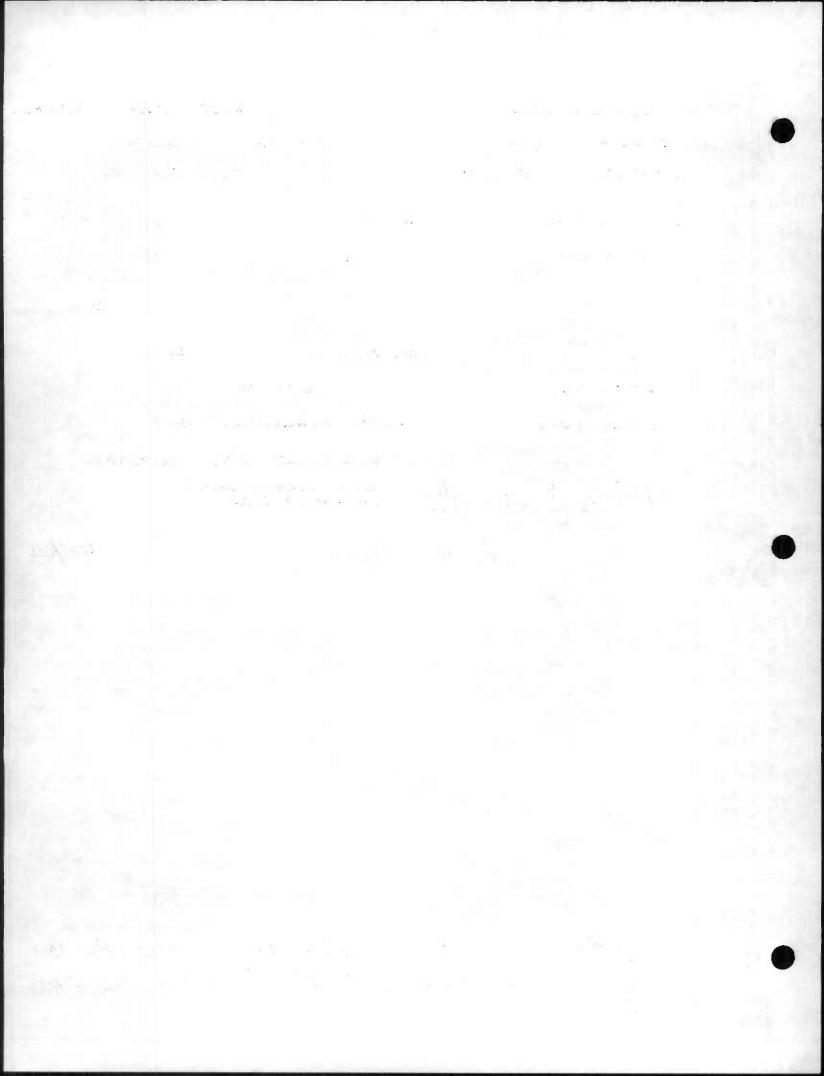
State of Maryland / Department of Health and Mental Hygiene

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F	Physic	an	Decedant's Name (First, Middle, Last NADV CLADVC 1	*					2. Data of Dea Month AUGUST	Day	Yaer	. Tima of Death
	/Medi	cal	MARY GLADYS H					lh Oite Taum as		22, 199		20:00
	Exami	ner	4a. Facility Nama (If not institution, given KENT AND QUEEN ANN				4	CHESTERT	Location of Daath	4c. County		
	Funeral		5. Social Security Number 6. S		a (In yrs. last		Undar 1 Yaer	If Undar 24 Hrs	8. Data of Birth			a (Stata or Foraign
ļ,	Director		213-10-3074	□м 21Д F	86	Yrs. Mo	nths Days	Hours Min.	April 17	, 1912	Pond to	own, Maryla
	pue M		Usual Rasidence of Decedant 10a. Stata 10b. County		10c City To	own or Location	n					
	Aaryle f sho	ŏ		A	Too. Oxy, To	OWIT OF EGGREGI						Inside City Limits 1 Yas XXNo
	T28a-	Director	Maryland Queen 10e. Street and Number	Annes		10	of. Zip Coda	ngton	1	0g. Citizen of W	Thet Country?	
	h with	a D	216 Spring Road				21651				ted St	
	deat	Funeral	11. Marital Status	12. Was Decedent I Armed Forcas?	Ever In U,S.	13. Was I	Decedant of Hi	ispanic Origin? (S	pecify Yas or No- lo Rican, etc.)		- American I	ndian,
21215-0020	s 1 end 2 should be filed within 72 hours elter death with the Maryland If Health end Mental Hygiene. Itam 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event, the Medical Exercites must be notified at	b	1 ☐ Navar Married 2 ☐ Married 3 ☐ Widowed 4 XXDivorcad	1 ☐ Yas 2 ☑X If Yas, Give Yaar or Datas:	No		as 2XXXVo	Specify:	0 (100.1)	Specify:	- 1	k
50	72 hc natur	Completed	15. Decedant's Ed (Specify only highest gra	ucation de complated)	10	6a. Decedant's	Usual Occupa	ation fu <i>ring most of wor</i>	rkina	16b. Kind of Bu	sinass/Indust	ry
12	vithin han	mpi	Elementary/Secondary (0-12)	College (1-4or 5	+)	lifa. DO N						
d 2	Hygie Hygie ther t		17. Fether's Name (First, Middle, Last)				Linewo		ma (First, Middla, I		annery	r
Maryland	should be and Mental I	To Be	George Hines					Katie Ha			.,	
ary	2 should be end Mental is marked aumatic ev	-	19a. Informant's Name/Ralationship (1	Type, Print)	1	9b. Mailing Ad	dress (Street		ıral Routa Number	, City or Town,	State, Zip Coo	de)
	s 1 end 2 rf Health e Itam 27 la other tra		Sarah Wright/Daugh	nter	3	10 Spr:	ing Roa	d, Milli	ington, M	aryland	21651	
Baltimore,			20a. Mathod of Disposition ★★★Burial 2 ☐ Cramation 3 ☐	Ramoval from State		of Disposition tary, cramator		a)	Data	20c. Location - 0	City or Town,	Stata
Ē	Peges Iment of It Itant: If Ita		4 ☐ Donetion 5 ☐ Other (Specify)	Mt. F	leasan	t Cemet	ery/Augi	ıst 28, 1	998 Pon	dtown,	Maryland
Ba	permit. Pege: Department of Important: If i any injury or once.		21. Signatura of Juneral Sarvice Licen	1		E-11	ma end Addres	1 C 1	n & Newna	m Funer	al Hom	ne. P.A.
	10144		23a. Pert1. Entar he diseesa, or compshock, or head failure. List only	Ellows	all a facial in	P. 0	Box 2	70, Mil	Lington,	Marylan	d 2165	1
	- Physiolog	3	shock, or hear failure. List only	ona causa on aach lir	ithe deeth. D	o not antar the	a moda or dyln	g, such as cardia	c or respiretory em	ast,	Inte	proximata erval Between sat and Death
	Physiclan /Medical		Immediate Causa (Final		men	Card	-0/-	Du farc	for		Oa	inita
	Examiner		disaasa or condition resulting in daath)			e consequance		July Josef C	-010-1		7717	nuves
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	tificate be executed g physician and as the burial-transit	Examiner	Sequantially list conditions, if any, leading to immediate cause. Enter Underlying	V	Dua to (or as	a consequance	e of):					
68760,	siclan buria		causa. Entar UndarlyIng Cause (Diseasa or injury thet initiated avants	C		Was						
	ifficate g phy as the	Aedical	rasulting in death) Lest		Due to (or as	a consequance	a of):					
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0.0	v requires that the de been signed by the should be deteched		Relmonary Fi	hiotis					1□ Y	es 2□ No	3 Probabl	y 4 Unknown
ds,	signe d be d	d by		0,000					Ode Mes		24h Wore	eutopsy findings
Records,	requ been shoul	Completed							24e. Wes e perfor		availat	ola prior to
Re	0 - 2	дшо							1 🗆 V	s 25 No	of daat	
	ician: The certificate rector, pag	Be Co	25. Was casa rafarrad to medical					28 Place of Dec	ath (Check only on		1 1	S ZLINO
5	Physician: rthis certific ral director.	0	axaminar?	Hospital:	nt 2 ER/	Outpetient 3	DOA Othe	25.	lome 5 Reside		r (Specify)	
Division of Vital	ding Phys h. After this funeral di	Dn: T	27. Mannar of Death 1 ☑Natural 5 ☑ Pending	28a. Data of Injur (Month, Day	Year) 28t	o. Tima of Injury	28c. Injury World		28d. Dascribe ho			
SIO	Attending or death. ector: After by the fune	catic	2 Accidant invastigation			M		Yes 2□No				
Ž	X # = =	Certification:	3 ☐ Suicide 6 ☐ Could not be detarmined	28a. Placa of Injubulding, ato		farm, straat, fa	actory, office		28f. Location (Si City or Town	reet and Number, Stata)	er or Rural Ro	uta Number,
	pital or ours eft erai Dir filled in		29a. Cartiflar 1 Certifying Phy	sician: To the best of	of my knowled	lae deeth see	ured at the tim	a dete and place	and due to the co	use(s) and mar	nner ee etete	4
	24 hos Fun letely	edical	(Check only one) 2 Medical Exam	Iner: On the basis of and mannar sta	axamination	end/or invastig	ation, in my or	pinion, death occu	rred at tha tima, d	ata and placa, e	nd dua to the	cause(s)
	To the Hospital of within 24 hours of To the Funeral D completely filled in	Me	29b. Signetura and titla of certifiar				29c. Licansa	number	/ 2	9d. Data signed	(Month, Day	, Year)
		3	· Capain	aun			DOD	354		8/24	198	
*			30. Nama and address of person who o	complated cause of de	eath (Item 23	B) (Type, Print)	Cir		ow, nd			
			C.G. BAURIANK			Kill Ka	CHE	STHETT	way Incl	21620	2	
	Sta Registr		31. Data filed (Month, Day, Yeer) 19	98 32. Hedistre	er's Slopatura	B.	Spark	2				



State of Maryland / Department of Health and Mental Hygiene 9 8 271, 11

							Ce	rtificate	of D	eath		Reg	, No.	Con 1	711	
	• Dhuaisian	1. Decedent	's Name (First, Mid	die, Last)							2. Dete Mont	of Death	Day	Year	3. Time of Death	
a di	Physician /Medical	El:	izabeth C	. Joh	nson								1,1998		11:45 P.	M
	Examiner		Name (if not instituti			nber)				. City, Town, o		Deeth	4c. County			
100			red Heart	-				If Under 1 \	,	umberla		(5) 41	Allega		(2)	
в	Funeral Director	214-0	07–2498	6. Sex	M X □ F	7. Age (In yrs. 84	lest birthday Yrs.)eys	Hours Mi	n. B. Date (Mont	of Birth th, Day, Y	1914	9. Birthplac Country MD	ce (State or Foreig	gn
	pue *	Usual Resid	lence of Decedent 10b. Coun	tv		10c. Ci	ity, Town or L	ocation						100	1. fnside City Limit	ts
	f sho	MD	Alleg				Cumber								Yes 2□N	
	ith the Marylen or 28a-f show		and Number	uriy				10f. Zip Co	ode			100	g. Citizen of V	Vhat Country	y?	_
	23a or 23a or 23a or 23 DI	932 9	Seton Driv	ve				215	502				USA			
	Homs 2	11. Marital S				dent Ever in U	J,S. 13.	Wes Decedent		panic Origin?	(Specify Yes	or No-		e - Americar		
21215-0020	s. 1 and 2 should be filed within 72 hours ofter death with the Maryland (F Hasilt) and Mental Hygiene. The file and Mental Hygiene. Other traumatic event, the Medical Examiner must be not filed at other traumatic event, the Medical Examiner must be not filed at To Be Completed by Funeral Director.		er Married 2 Ma		Armed For 1 Yes I If Yes, Giv Year or Da	X□ No e		1 Yes X□		Specify:	onto ritari, et	<i>G.</i>)	Specify	k, White, et wh	ite	
2-0	72 ho		15. Decede (Specify only high	ent's Educa	itlon		16a. Dece	edent's Usual C	occupat	tion uring most of w	vorkina	16	6b. Kind of Bu	uslness/Indu	stry	
21	ithin no no no no		ry/Secondary (0-12)		College (1	-4or 5+)		DO NOT use r		ing most of it	o, many		Dt-27.			
CA	N Per th		.2	. 4 4			Former	Employ		an Markada N	anno (First &		Textile			_
Maryland	should be filed within 72 hours eft not Metal Hygienath Hygienath; or runakte other than "natural", or umatic event, to Medical Exam. To Be Completed by F		Neme (First, Middle es N. Lon							18. Mother's N Jesse		nuoie, ivia	noen Suman	10)		
lan	2 sho end Is me	19a. Informa	ant's Name/Relation	nship (Type	e, Print)			ing Address (S						State, Zip C	ode)	
	i Health if Health item 27 other tr		Longne	phew		1		gwood L	-	Wiley	_			0.		
ore	00		of Disposition rial 2 Cremation	3 □Rer	movel from 5	State	cemetery, cre	osition (Neme emetory or othe	er place		Date		Dc. Location -			
		4 Dor	nation 5 Other	(Specify)		Hi		t Memor			08/14		umberl	and M	D	
Bal	permit. Pa Depertmen Important: any Injury	21. Signatu	to holas	, l	DAM	und	0;	Scarpe Cumber	elli Lan	Funeral MD 2	al Hom 1502	e, P	.A.			
		23a. Pert1. shock.	Enter the disease, or heart failure. Li	or complica	ations that co	sused the dea	th. Do not er	nter the mode o	of dying	, such as card	iac or respire	tory erres	it,	1	Approximate nterval Between	_
	Physician			0			_	0, .							Onset end Death	
1	/Medical Examiner	disease or or resulting in	Cause (Finel condition	a.	1	cute	2 4	oppos	2						TOHRS	
	STATE OF THE PARTY.	1030kiilg iil	dodiny			Due to (or as a cons	ytuence of):								
	exacuted in end riel-transit Examiner	123		b		D h . /								i		
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68760,	requires that the death certificate be executed seen signed by the ettending physician end hould be deteched for use as the buriel-transit eted by Physician/Medical Examir	Cause (Dise	y list conditions, ng to immediate er Underlying ease or Injury d events	C		Due to (or as a conse	quence of):	-			_				_
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Вох	es that the death certificated by the ettending be deteched for use e by Physician/M			d										-		
. E	the ett the ett hed fo	Part II. Othe	r elgnificant condi	tione contr	ibuting to de	ath but not re	sulting in the	underlying caus	se give	n in Part I.	23b	. Did tob	acco uae col	ntribute to t	the cause of deat	th?
P.0	at the											1 🗆 Yes	20 No	3 Probe	ibly 4 Unkno	wn
Ś	igned by the detect of by detect of by Phy													T 0.45 W		
Records,	The law require sete hes been si page 2 should I										24a	. Was en performe	eutopsy ed?	avail	e eutopsy findings lable prior to pletion of cause	5
	2 2 S													of de	eath?	
=	ysician: The law s certificete hes director, page 2 To Be Comp											1 🗆 Yes	2010	10	Yes 2 No	
Vital	Physician: rthis certific and director, TO Be	examine			spital:	/			Othe	26. Place of D				10 11		_
o	this ald	1 Yes			124		28b. Time		. Injury Work	4 U Nursing	-		v Injury occur			
Division	taf or Attending P rs effer death. al Director; After t led in by the funera Certification;	1 Natu 2 Acc		ding stigation	(Mont	of tnjury h, Day Year)	Injury	М		? 'es 2□No						
/isi	Attendi r death octor: A by the fi	3 ☐ Sul	cide 6 □ Coul		28e. Place	of Injury - At h	nome, farm, s	treet, factory, o	office		28f. Loca	ation (Stre	et end Numb	per or Rural	Route Number,	
Ö	s efte od in	4 ☐ Hor	micide	/	DURGIT	ng, etc. <i>(Spec</i>	iry)				Ony	Or TOWN,	31616)			
	To the Hospital or Attending I within 24 hours eiter death of To the Funeral Director; After completely filled in by the funeral Medical Certification	29a. Certific (Check one)	only 2 Medica	ring Phyalo al Examina	cian: To the er: On the ba	isis of examin	owledge, dea ation end/or i	th occurred at investigation, in	the time my op	e, date end pla inion, deeth oc	ca, and due courred at the	to the cau	use(s) and me te and plece,	enner as sta and due to t	ted. the cause(s)	
	Vithin Somple	29b. Signati	ure and tale of ceal	iec/				29c. L	icense	number		29	d. Date signe	d (Month, D	ay, Year)	
	(5)	•	Me	1 ag	M	ww	2	1	\supset	2218	81	A	AUGUST	12	,1998	
	Olb.		nd address of perso	on who for	pleted caus	e of death (Ite	m 23a) (Type	op Wa	101	Q1.	1	hon	10.00	M	21510	
	0		ary Was	D. LE	-/1.D.	705	D 15 P	op VV4	(13 /	1114,	um	ver'	una,	IND	0/302	-
	State Registrar	OT. Date life	ALIC 1 . 1	1000	9 de	egistrar's Sign	Risch4									
			MUUI 3	1330	9											_



П			1. Decedent's Nar	me (First, Middle	, Last)							2. Date of De	eath	Vaca	3. Tir	ne of Death
	Physic /Medi		BERNA	ARD MARV	IN JONES							Aug 7,	1998	Yeer	023	12
	Exami		4a. Facility Name	(If not institution	give street and n	um <i>ber)</i>				4b. City, T	own, or L	ocation of Deat		y of Death		
			MEMORI	AL HOSP	ITAL					CUMBI	ERLAN	ID	ALLEC	GANY		
	Funeral Director		5. Social Security 217–18–	4561	6. Sex X □ M 2□ F	7. Age (in yr 76	rs. last birthday) Yrs.	If Under Months	1 Year Days		Min.	8. Date of Bi (Month, Di Apr 1	y, Yeer)	9. Birth Cou W	place (Si Intry)	tate or Foreign
	and *		Usual Residence	10b. County		10c. 0	City, Town or Lo	ocation					_	-	10d Inei	de City Limits
	with the Maryland a or 28a-f show	Director	MD	Allega	ny		Cumber									Yes 2 No
	th with the 23a or 2		10e. Street and No.	_{umber} dford Ro	oad			10f. Zip (Code	2			10g. Citizen of US.		ntry?	
020	or items	by Funeral		rried 2□ Marri	ed Yes	cedent Ever in orces? 2 No live Dates: WWI]		Was Decede If Yes, speci 1 ☐ Yes	_			ecify Yes or No Rican, etc.)	14. Ra Bie Specii	ce - Ameri ck, White, by:		,
1215-0	C 7 6	Completed	Elementery/Sec		grade completed) (1-4or 5+)		dent's Usuel kind of work DO NOT use			st of work	ing	16b. Kind of 8			tion
Maryland 21215-0020	al Hygi I other vent,	o Be	12 17. Fether's Name Ernest	(First, Middle, L			Retire	a Cal	Ter	18. Moth		e (First, Middle	CSX Tr , Maiden Sumer	-	orta	CTOU
lary	01 (0 (0)	F	19a. Informant's h				19b. Maili	ng Address	(Stree	_			er, City or Town	, State, Zl	o Code)	
	1 and 2 Health em 27 i		James D	. Jones	-son						e Cum	berland	MD 215	502		
altimore,	Pagas 1 and nent of Head ant: if item arry or other				3 □Removal from	Julie	Place of Dispo cemetery, cree Cky Gar				n. (Date 08/12	20c. Location Flints			te
Balt	permit. Paga Department of Important: if any Injury or once.		21. Signature of F	unerel Service L	iconson	Aud	A 25		el.	ess of Facil li Fu and M	_{lity} nera]	L Home,				
	Physician /Medical Examiner	ler	shock, or he Immediate Cause disease or conditi resulting In death)	(Final	a. Cor	onary	Artery	Dise							7 Ye	cimate I Between and Death
68760,	tath certificate be asscuted attending physician and for use as the burial-transit	cian/Medical Examiner	Sequentially list of any, leading to i cause. Enter Und Cause (Disease of that Initiated even resulting in deeth)		b		(or es e consec									
Box	anding use	M/V			d											
P.O.	0 0 0	Physi	Part II. Other signi	ificant condition	e contributing to d	leath but not re	esulting In the u	nderlying ca	use gi	ven in Part	I.		tobacco use co	ontribute t		use of death?
I Records,	HECOLGS, P.O. he law requires that the has been signed by the	Completed by											en eutopsy ormed?	of of	veilable p	n of cause
Vital		Be (25. Was case refe examiner?	rred to medical			-			26. Plac	e of Deet	h (Check only	one)			
of	2 00	2	1 ☐ Yes 2 1	No			DER/Outpatier		4		ursing Ho	me 5 Resi	dence 6 □Ott	ner (Speci	fy)	
ion	D e	ation:	27. Manner of Dea 1 DNatural 2 ☐ Accident	5 Pending Investiga	ation	of Injury oth, Day Year)	28b. Time o Injury	M 28	C. Inju Wo	nyat ork?]Yes 2 [28d. Describe	how Injury occur	rred		
Division	o at a	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Couid no determin	ot be ned 28e. Plac build	e of Injury - At ling, etc. (Spec	home, farm, str	eet, factory,	office			28f. Location (City or To	Street and Num wn, State)	ber or Run	al Route	Number,
	e Hospital	edicai (29a. Certifier (Check only one)	12 Certifying	Physician: To the xaminer: On the b	best of my kr pasis of examination of stated.	nowledge, deetl nation end/or in	occurred a vestigation,	t the ti	ime, date a opinion, de	nd place, ath occur	and due to the red at the time,	ceuse(s) and m date and place,	enner es s end due t	iteted. o the cei	use(s)
	Within To the comp	M	29b. Signature and	d title of certifier	1/5			29c.	Licen	se number			29d. Date signe	ed (Month,	Day, Ye	ar)

D36766

21502

Aug. 10, 1998

JONES, BERNARD MARVIN

State Registrar

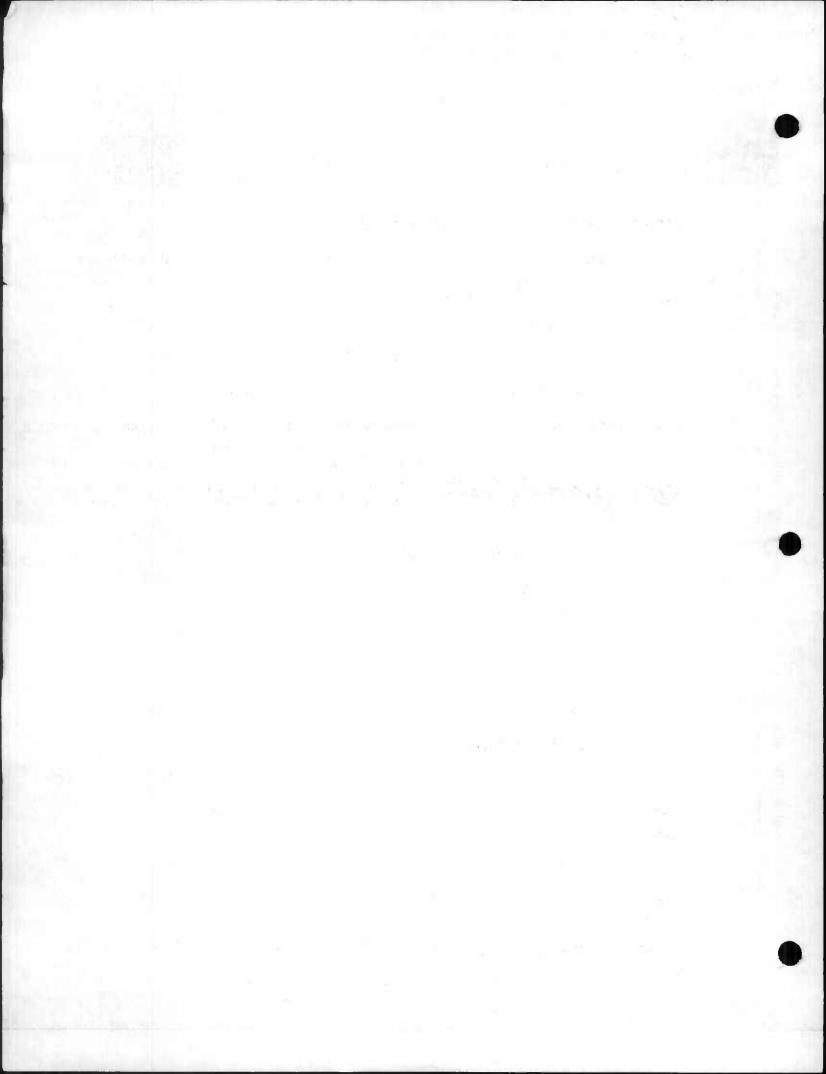
30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

Dr. Vik Poonai; 922 National Hwy; LaVale, MD

31. Date filed (Month, Dey, Year) Registraris Signature

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

					Ce	ertificate o	f Death		1	Reg. No.		
Physic /Medi		1. Decedent's Neme (First, Middle, Last) LENT CLIFTON JOHNSON, JR 2. Dete								Day Year 3. Time of		
Exami		4e. Fecility Neme (If not institution, git		or)			4b. City, To	-	cation of Deeth		of Deeth	404>
Funeral Director		577-40-2584 1\(\frac{1}{2}\)M 2□ F			e (In yrs. last birthday) 88 Yrs. If Under 1 Year If Under 24 Hrs. Months Deys Hours Min.						lece (State or Foreign try) raska	
Maryland H show	tor	Usuel Residence of Decedent 10e. State 10b. County Maryland Montgo	merv		y, Town or	Location					10	0d. Inside City Limits
with the	I Director	10e. Street end Number	at end Number				60			try?		
permit. Peges 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiana. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f ahow important: if Item 27 is marked other than "hatural", or Items 23a or 28a-f ahow hiptry or other traumatic event, the Medical Expriner must be notified at ance.	by Funeral	16600 Oakhill F 11. Maritel Stetus 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Wes Deceder Armed Force: 1 X Yes 2 If Yes, Give Year or Detes	s? World	d_	208 Wes Decedent of If Yes, specify Control of Yes 2 N N	f Hispanic Or uben, Mexice	n, Puerto F	cify Yes or No Ricen, etc.)	- 14. Rad		en Indien, etc.
72 hou natural	eted t	15. Decedent's E	ducation	war	16e. Dec	edent's Usuel Occ ve kind of work dor	upetion	st of workin	10	16b. Kind of B	Whi usiness/Indi	
within and the state of the sta	Completed	Elementary/Secondery (0-12)	College (1-4o	r 5+)	life.	DO NOT use reti	red)	N OF WORKE	ig .	Unite		tes
Hygie other	Be Co	17. Fether's Neme (First, Middle, Las	5+		Pn	ysician	18. Moth	er's Name	(First, Middle,	Gover Maiden Surnan		
should be ind Mental marked umatic ev	To B	Lent Clifton J	ohnson, S	Sr.			Jo	hanna	Matil	da Ston	e	
2 sho		19e. Informent's Neme/Relationship	Type, Print)	1.7	19b. Ma	iling Address (Stre	et and Numb	er or Rurai	Route Number	er, City or Town,	State, Zip	Code)
of Health of Health I Item 27 i		Lent Johnson / so 20e. Method of Disposition 1 Buriai 2 ACremetion 3 [20b. F	2505 Hyacinth Avenue, Hannibal, Missouri 63401- 20b. Place of Disposition (Name of cemetery, crematory or other place) August 23, 1998 2505 Hyacinth Avenue, Hannibal, Missouri 63401- 20c. Location - City or Town, State								
permit. Peges Department of I Important: If Ite any injury or o	1 25	4 Donetion 5 Other (Speci	(y)	Mo:	ntgome	ery Crema 22. Name end Add	torium	n, Ind	с.	Bethesd		
8 2 2 5 8		Embarage Mon	rullenta	uren	ce	obert A. P 7557 Wiscon	umphrey sin Ave	runer nue, B	al Home/ ethesda.	Bethesda Marylan	-Chevy 1 2081	Chase, Inc 4-3501
aath certificeta be executed ettending physician end ifor use as the buriel-trensit	n/Medicai Examiner	Sequentially list conditions, if eny, leading to Immediate cause. Enter Undertying Ceuse (Diseese or Injury that initiated events resulting in death) Lest	b. ATRIAL	Due to (c	r es e cons	equence of): equence of): equence of):						
that the daath ce led by the ettendi detached for us:	Physician	Pert II. Other significant conditions of OTARRES MEU		but not res	ulting In the	underlying ceuse	given in Pert	l.	23b. Did 1	~		the cause of death
aw requiras is been sign 2 should be	Completed by	CARCINOMA O	F BROSTA	te						en eutopsy med?	com	re eutopsy findings lleble prior to apletion of ceuse leeth?
The lav ate has page 2	Com								101	res 2 No	1 🗆	Yes 22 No
ician: The cartificate rector, pag	Be	25. Wes case referred to medical exeminer?	Uganitati					e of Death	(Check only o	one)		
this aldi	tion: To	1 Yes 2 No 27. Menner of Deeth Naturel 5 Pending investigation	Hospital: 1 Inpa 28e. Date of In (Month, L	jury	ER/Outpeti 28b. Time Injury	of 28c. In		2	-	dence 6 Doth		1
a or Atter s efter dea I Director of in by th	Certification:	3 Suicide 6 Could not be determined	280. Place of I	njury - At ho etc. (Specif	ome, farm, s	street, factory, office	е	2	8f. Location (S City or Tox	Street end Numi vn, State)	per or Rural	Route Number,
To the Hospital or Attending is within 24 hours efter death. To the Funeral Director: After completely filled in by tha funar	edicai C	29a. Certifier (Clack only only) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menn only only only only only only only on									enner es ste end due to	ited. the ceuse(s)
	Ž	29b. Signature end title of certifier	Tir.				nse number	_		29d. Dete signe		
20+1		M.O. 015236 DI						DM	IE AUGUST 21, 1998			
			completed cause of	deeth (Iten	23e) (Type	e, Print)	BIKE	180	ckulu	E, M	0 20	852
Sta Registi		31. Dete filed (Month, Day, Year) AUG 2 4 199	32 Regis	strer's Signe		Spork						



	1. Decedent's Na	me (First, Middie.	, Last)				-	10010 01	Death		2. Date of D	Reg. No.		3 Time	of Deet	
an				er J.	Jako	0					Month	Day	Year			
al er	4e. Fecility Name	(If not institution,	, give stre	et end nu	m <i>ber)</i>				4b. City, To	wn, or Lo	August cation of Dea		1998 nty of Death	10:	55PM	
	VA Mary	land Heal	lth (Care	Syste	em.			Perry	z Po:	int	Cec				
	5. Social Security	Number	6. Sex		7. Age (In	yrs. last birt	M	Under 1 Year onths Deys	If Under		8. Date of Bi (Month, D			place (Ste	te or For	
Funeral Direc	218-28-		X	RM 2□F 65			Yrs.			TIOUIS MIII.		27,1933	l l	Maryland		
	10a. State	Jsual Residence of Decedent 10a. State 10b. County				10c. City, Town or Location							10d. Inside City Limi			
	Maryland Cecil							Per	ryvil	1 _e		1 X Yes 2 □				
	10e. Street and Number						1	Of. Zip Code	- 7			10g. Citizen of What Country?				
	724 Broad Street								2190	3	U.S.A.					
	11. Marital Status			12. Was Decedent Ever in U,S. Armed Forcas?			13. Was	Decedent of	Hispanic Orig	gin? (Spe	cify Yes or N		4. Raca - American Indian,			
		rried 2 Marrie	ed	1 X Yes	2 □ No			s, specify Cub		, Fuerto	mican, etc.)		lack, White,	etc.		
d by	3 Widowed	4 Divorced		Year or D	ates: 195							Spec	WI	nite		
ere	(Spe	s Education t grede co	(e completed)			Decedent'	s Usuai Occu of work done	pation during most	of worki	16b. Kind of Business						
Completed	Elementary/Secondary (0-12) Ten Years			College (1-4or 5+)			(Give kind of work done during most of work life. DO NOT use retired) Mail Courier						V.A. Medical Perry Point,			
	17. Father's Name	.est)							r's Name	(First, Middle	, Maiden Sume		-, rid	тут		
To Be			nknov	wn							Sophie					
_	19a. Informant's N					19b.	Mailing A	ddress (Stree	t end Numbe	r or Rura		er, City or Tow	n, Stete, Zip	Code)		
	Frances	Oelke (Siste	er)		5	Ports	ship Ro	ad, Di	unda	lk, Man	ryland	21222			
	20a. Method of Di		0			0b. Place of cemeter	Dispositio	n (Neme of ary or other ple	ca)		Date	20c. Location	n - City or To	own, State		
		2 ☐ Cremation 3 5 ☐ Other (Spe		oval from	State					ry 8	/26/98	Owings	Mills	s, Ma	ry1a	
	21. Signature of Funeral Service Licensee 22. Name and Address of Facility															
	Allen	Mican	JTH-	47	000	Sr						ineral				
	23a. Pert1. Enter	the disease, or c	Perryville, Maryland 21903-0188 23a. Pert. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest,												1.75	
	shock, or heart failure. List only one cause on each line.						not enter th	e mode of dy	ng, such as	cardiec o	r respiratory a	arrest,		Approxir	nate	
		art failure. List o	only one ca	ause on e	ech line.	deeth. Do n	not enter th	e mode of dyl	ng, such as	cardiec o	r respiratory a	arrest,		Approxir Interval I Onset ar	Betweer	
	Immediate Cause disease or conditi	(Final	only one ca		neumo		not enter th	e mode of dyl	ng, such as	cardiec o	r respiratory a	arrest,	į	Interval	Betweer nd Deat	
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niner	disease or conditi	(Final	a		neumo	onia			ng, such as	cardiec o	r respiratory a	arrest,	į	Onset ar	Betweer nd Deati	
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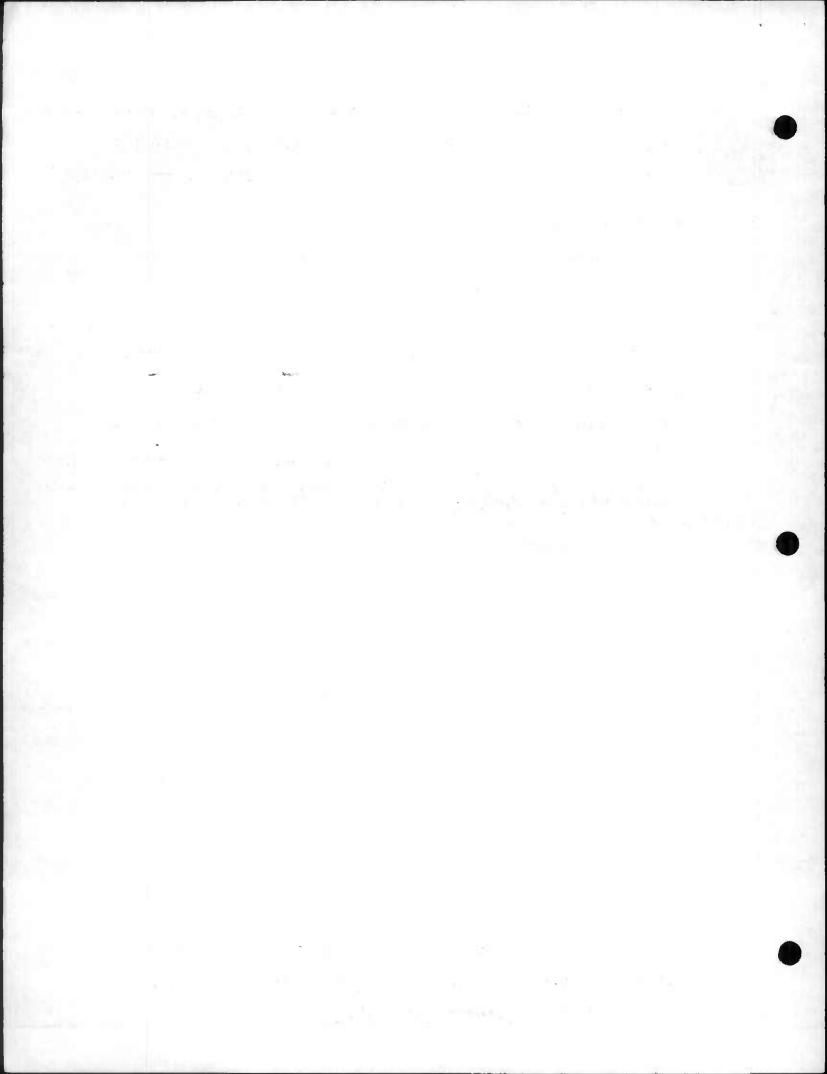
DHMH 16 Rev 6/95

NAME KNOWN TO PHYSICIAN: JAKO, WALTER Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

ITITEM:	#8	PER F.H. G766112-19-98 W	State of Maryla		tment of I ficate of			giene g	8 27	415
Physi		1. Decedant's Nama (First, Middla, Last					2. Data of Da Month		3. T	ima of Deeth
	dical	Ethelyn 4a. Fecility Nama (If not institution, giva	Lord street and number)		Jone			20, 19	98 9:	55 PM
Funera Directo	al	Salisbury Center: 5. Sociel Security Number 216-01-3045		. last birthdey)	If Under 1 Yaar Months Days	Salisbur If Under 24 H Hours Mi		Wicom:	ico	Stata or Foraign
yland		Usual Residence of Dacedant 10a. Stata 10b. County	10c. C	ity, Town or Local	tion					sida City Limits
the Mar 28a-f st	Director	Maryland Wicomico	S	harptown				10- Ohi(1)		Yas 2 No
with po so	급	501 Ferry Street			10f. Zip Coda	861		10g. Citizan of V USA		
Z1Z1S-UUZU within 72 hours effer death with the Maryland liene. rthan "netural", or items 23a or 28a-f show the Maryland I was the Maryland I wa	Funeral	11. Marital Status 1 Naver Married 2 Marriad	12. Was Decedent Evar in U Armed Forces? 1 ☐ Yas 2 ☒No If Yas, Giva	lf Y			(Specify Yas or No arto Rican, atc.)	- 14. Rac Blac	e - Amaricen Ind k, Whita, atc.	ian,
2 hours	ted by	3 ☑ Widowad 4 ☐ Divorced	Year or Datas:	16a. Decedan	t's Usual Occup	pation			White	
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Marylan d 2 should be f th and Mental I 7 Is marked of traumatic eve	10	Clayton Lord 19a. Informant's Name/Raietionship (Ty	no Printl	10h Mailine	A diducacy (Chrock		E. Kenne		Charles 7'- On de	
s 1 end 2 s f Health an ftem 27 is 1		Betty Marine/Daugh	ter	P. O.	Box 374	, Sharp	Ru <i>ral Rout</i> a Numbe town, Mar		21861	'
Pages 1 ent of H ht: If Iter		20a. Mathod of Disposition 1 X Burial 2 ☐ Crametion 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	amoval from Stata	Place of Dispositi cematary, cramatary			Data 8/24/98	*	City or Town, St	
Baltimore, permit. Pages 1 end Depertment of Healt Important: if Item 21	- Alica	21. Signatura of Juneral Sarvica Licanso		22. N	ama and Addra	ss of Facility	me, 1212	-		-
-	1	28a. Parri. Entar tha diseasa, or complishock, or haart failura. List only or	cetions that caused tha dae	P. oth. Do not entar t	O. Box ha moda of dyir	3171, Sang, such es cerdi	alisbury, ac or raspiratory a	MD 21	802 Appro	oximata al Batween
Physician /Medica Examine	ı 🗀	Immadiata Causa (Final diseasa or condition rasulting in death)	Dana	Sia					Onse	t end Death
Toda.		Table 11 Guarry	Dua to (or as e consequa	nce of):					
6 / 6U, sete be executed shysician end the buriel-transit	Examiner	Sequantially list conditions, if any, laading to Immadiate ceusa. Entar Undarlying Causa (Disaasa or injury	Dua to (or es a consaque	nce of):		_			
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death certific e attending p	ician	Part II. Other significant conditions con	tributing to death but not re-	sulting in the unde	idvina cousa di	ran in Part I	23h Did	tobacco use con	atribute to the c	auga of death?
d by th	by Phys	ge 96	tibuting to doubt but not tak	sutting in the once	arying cousa ga	carr arr catt.		Yes 2□ No		-
aw requir	Completed	J					24a. Was parfo	an autopsy mad?	24b. Wara aut evailabla complatio of daath?	prior to on of causa
= F # &	e Com	OS Was against a madical					101		1 □ Yas	2□ No
Physician: this certific ral director,	00	25. Was casa rafarrad to medicel examinar? 1 ☐ Yas 2 ☐ No	ospital:] FD/0	all post Oth	ar.	eath (Check only o			
tending Physical OI Cor. After this the funeral di	tion: To	27. Mannar of Daeth 1 Matural 5 Panding 2 Accidant invastigation	1 ☐ Inpatiant 2 ☐ 28a. Data of Injury (Month, Day Year)	28b. Tima of Injury	28c. Injur Wor	4 La Tyursing	Homa 5 ☐ Rask	dance 6 ∐Othe		
or A	Certification:	3 Suicida 6 Could not be datarminad	28e. Place of Injury - At h building, atc. (Spaci	noma, farm, straet	, factory, office		28f. Location (S City or Tov	Straat and Numb vn, Stata)	er or Rural Rout	a Number,
To the Hospital within 24 hours a To the Funeral Completely filled	edicai	29a. Cartifiar 1 Cartifying Physics (Check only one) 2 Medical Exemination	iclan: To the bast of my knower: On the basis of axamina and mannar stated.	owladga, daath oo ation and/or invas	curred at tha tir tigation, in my o	na, data and plac pinlon, daath oc	ce, and dua to tha curred at tha tima,	causa(s) and ma data and placa, a	nnar as stated. and dua to tha ca	ausa(s)
withir To th comp	W	29b. Signatura and titla of certifiar	110		29c. Licans	a number		29d. Data signad	(Month, Day, Y	aar)
		30. Nama and addrass of person who co	mplatad ceusa of daath (Ital	m 23a) (Type, Pri	D 29	349		1/21/9	8	
		William H. Robins,	M.D. 110	4 Health		, Salis	bury, MD	21804		
S Regis	tate trar	31. Data filed (Month, Day, Year) ALIG 2.7 1998	32. Pjegistrar's Sign	atura 4	100 1	-				

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State of Maryland / Department of Health and Mental Hygiene

			Ce	ertificate of	Death		Reg. No	J 0	61	416
	1. Decedent's Name (First, Middle, Last)				2. Date of Month	Death	21/	Year 3.	Time of Death
Physician /Medical	ANNA SWAUGER	KIMMELL				AUG		0 199		6:30 AM
Examiner	4a Facility Name (If not institution, give	street and number)			4b. City, To	wn, or Location of D	eath 4	c. County o	of Death	
	SACRED HEART	HOSPITAL			CUMBI	ERLAND		ALLE	GANY	
Funeral Director	5. Social Security Number 6. Se 212-38-7262 Usuat Residence of Decedent	X 7. Age (In)	56 Yrs.	Months Days		Min. (Month,	Birth Day, Year 1,19		9. Birthplace Country) MARYL	(State or Foreign
death with the Maryland ms 23s or 28s-f show r mast be rediffed at neral Director	10a. State 10b. County	10c.	City, Town or I	ocation						nside City Limits
a-fa	MARYLAND ALLEG	ANY	CUMBER	LAND					1	☐ Yes 2 No
ith the Mai	10e. Street and Number			10f. Zip Code			10g. C	itizen of W	hat Country?	
ath w	13000 PEACH S			215				USA		
should be filed within 72 hours efter death with the Marylan of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show imstic event, the Medical Examt se must be notified as matter overt, the Medical Examt se must be notified as matter overt.		12. Was Decedent Ever i Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	n U,S. 13	. Was Decedent of If Yes, specify Cu		gin? (Specify Yes or , Puerto Rican, etc.)	No-	Black	WHITE	
2 hou		cation		edent's Usual Occi			16b. i		siness/Industr	
ed within 72 ho ygiene. Ar than "natural A, the Wedeal Completed	(Specify only highest grad	College (1-4or 5+)	life.	re kind of work don DO NOT use retir	e dunng mos red)	t of working				
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2 should be and Mental is marked or aumatic ev						RGIA GL				
2 sh and is ma	19a. Informant's Name/Retationship (T)					er or Rural Route Nu				(6)
Tand Health	GARY L. KIMMELL 20a. Method of Disposition			00 PEAC	H ST.	CUMBE Date			D 21	502 State
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Town of the Party of	4 Donation 5 Other (Specify)			REMATOR 22. Name and Add		11,19	98 M	ORGA	NTOWN	, WV
permit. Pa Department Important: any injury attos.	21. Signature of Funeral Service Licens	11				OF THE	HILL	S MO	RTUAR	Y
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Physician /Medicai	Immediate Cause (Final	41 -1	1 #	/-	(B) a	-1	1			
Examiner	disease or condition resulting in death)	. Met	-014e1	110	ca	07	C 41	000	0 2	-/00
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The law requires that the death or tie has been signed by the attend page 2 should be detached for us completed by Physician/	Part II. Other significant conditions con	ntributing to death but not	resulting in the	underlying cause g	given in Part I	. 23b.	Old tobacc	o uae con	tribute to the	cause of death?
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ysician: The last certificate had director, page	25. Was case referred to medical examiner?	Unanitat:				of Deeth (Check o	nly one)			
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To the Hospital or Attending Physician: Within 24 hours felse death. To the Funeral Director-Atter this certifical completely filled in by the funeral director, Medical Certification: To Be (27. Menner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Yea		M 11	☐ Yes 2 ☐	No				and a Marine barre
al or At a Direct ed in by	4 Homicide determined	28e. Place of Injury - / building, etc. (Sp	At home, farm, s ecify)	street, factory, offic	0		Town, Sta		er or Rural Ro	ute Number,
ne Hospit n 24 hour ne Funera pletely filli edical		sician: To the best of my ner: On the basis of exam and manner stated.								
ithin ithe outher on the outher omple	29b. Signature and tit and certifier	and mariner stated.			nse number				(Month, Day,	
	Vance	a w			08	377	4-	M	1/2 100	0.0
15	30. Name and address of person who co	ompleted cause of death	ttem 23e) (Tree	e Print)		umberle	Al	JGUST	10,19	70
MIS	11-11/11	NA 9	102 60	to Dr	1100	Junh -1	and	MI	16 (502.
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State Registrar

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		State of Mai	ryland / [Department of Certificate		d Mental		ene) 8	27	4	7
	1. Decedent's Neme (First, Middle, Las	et)				2. Date				3. Tim	ne of Death
in	Dennis Ray	Kelley	7			Augu	h 1St	21, 199	Year 98	12:	:15 AM
al	4a Facility Name (If not institution, give				4b. City, Town,			4c. County			
er	4853 Cordell A	venue, #141	L7		Betheso	la		Montg	omerv		
	5. Social Security Number 6. Se		(In yrs. lest bir	thday) If Under 1 Y	ear If Under 24	Hrs. 8. Date	of Birth			ace (St	eta or Foraign
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	10e. State 10b. County		10c. City, Tow	n or Location					10	d. insk	de City Limits
to	Maryland Montgom	ery	Bethes	sda						17	Yes 2 □ No
26	10e. Street and Number			10f. Zip Co	de		10	g. Citizen of V	Vhat Count	ry?	
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era	11. Marital Status		er in U.S.	13. Was Decedent	of Hispenic Origin	(Specify Yes	or No-	14. Rac	e · America	n India	ın,
F	1 Never Married 2 Married	12. Was Decedent Ev Armed Forces? 1 X Yes 2 □ No If Yes, Give	1965-	-	of Hispenic Origin Cuban, Mexican, P	uerto Rican, et	c.)	Bied	k, White, e	tc.	
by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Yeer or Detes:	1969	1□ Yas 2Ď	No Specify:			Specify	Whi	te	
Be Completed by Funeral Director	15. Decedent's Ed	ucation	16a.	Decedent's Usuai O	ccupation		1	6b. Kind of Bu	siness/Inde	ustry	
piet	(Specify only highest grad			Decedent's Usuai O (Give kind of work d life. DO NOT use n	one during most of etired)	working					
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TOB	William Kelley				Glady	s Oldf:	ield				
_	19a. Informant's Name/Ratationship (7 Tammy L. Marcuzzo			o. Mailing Address (Si 170 Blacks							3456
	20e. Method of Disposition		20b. Place o	Disposition (Nama	of	Date	2	0c. Location -	City or Tov	vn, Stal	te
	1 Buriai 2 Cremation 3 D			ry, crematory or otha apeake Cre		8-22-9	98 B	eltsvi.	11e. 1	Mar	vland
	4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service License		Onebe		-						,
	21. Signature of Fulleral Service Licens	~ 0			ddress of Facility eral Serv						
	avoll	1 Doll	_		Avenue,				-	-	20910
	23a. Pert1. Enter the disease, or comp shock, or heart failure. List onty of	plications that caused the one cause on each line	ne death. Do	not enter the mode of	dying, such es car	diac or respire	ory arre	st,			Between
										Unset	end Deeth
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cal	that initiated events resulting in death) Last	Di	ue to (or as a	consequence of):							
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SIC	Part II. Other significant conditions co	ontributing to death but	not resulting l	n the underlying caus	e given In Part I.	23b	. Did tot	acco use co	ntribute to	the car	use of death?
F S							1 🗆 Ye	2 No	3 □ Prob	ably	4 Unknown
by			-			_					
Be Completed by Physician/Med						24a.	Was an	autopsy ed?	eve	ilable p	psy findings prior to
ple									of d	npletion leeth?	n of cause
E							1 ☐ Yas	s 2 No	10	Yes	2 No
9	25. Was case raferred to medical				26. Place of	Death (Check	only one)			
TOB	ayaminar? 37	Hospital: 1 ☐ inpatient	2 ER/O	utpatient 3 DOA	Othor	na Home 5X			er (Specify	1	
1: 1	27. Manner of Death	28a. Date of Injury	28b.	Tima of 28c.	Injury at Work?	9		w Injury occur			
tioi	1 XNatural 5 ☐ Panding 2 ☐ Accident investigation	(Month, Day	Year)	Injury M	Work? 1 ☐ Yes 2 ☐ No						
1Ca	3 Suicide 6 Could not be		v - At home, fa	arm, street, factory, of	fice			eet end Numb	er or Rural	Routa	Number,
P	4 Homicida determined	building, etc.	(Specify)			City	or Town,	Stete)			
Medical Certification:	(Check only 2 Medical Exam	/alclan: To the best of liner: On the basis of e									usa(s)
60	one)	and manner state									
2	29b. Signature and title of certifier	a Sofn	na	29c. Li D43	cense number			d. Date signe .ugust			eer)
	30. Name end address of person who d	completed cause of des	ith (Item 23a)	(Type, Print)							
	George Sotos, M.D				ve, #300	Rockv	ille	, Mary	land	20	850

State Registrar

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Physician /Medica Examine

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours effer death with the Maryland Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "naturef", or items 23s or 28=f show early injury or other treumatic event, the Wolfrell Examinet must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

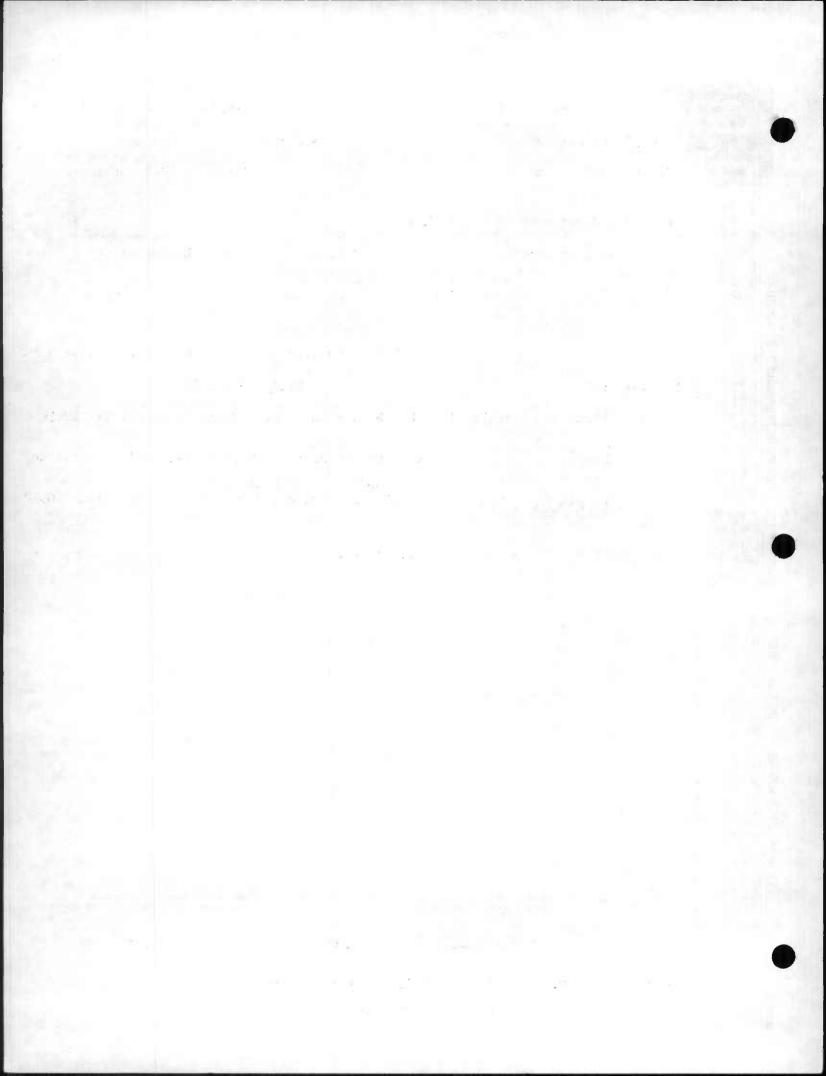
To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be deteched for use as the buriel-transit

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

31. Dete filad (Month, Day, Year) AUG 2 4 1998 32. Registrar's Signature

b. Sparke



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 202 1998ar AUGUST ZELMA 7:28 am /Medical 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner HOLY CROSS HOSPITAL SILVER SPRING MONTGOMERY 5 Social Security Number If Under 1 Yeer If Under 24 Hrs. 7. Age (In yrs. lest birthday) Date of Birth (Month, Dey, Yaar) 9. Birthplace (State or Foreign ARMA) MO **Funeral** Months Days Hours 1 □ M 2√□ F 366-05-2967 85 Yrs Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examiner must be notified at 1 Yes 2 □ No Director MONTGOMERY SILVER SPRING MARYLAND 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 9040 20901 UNITED STATES SAFFRON LANE Funeral Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Maritel Stetus 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - Americen Indien, Black, White, etc. filed within 72 hours after Hygiena. 1 Yes 27 No If Yes, Give Yeer or Dates: 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE P 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) **BOOK KEEPER** RETAIL permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itan 27 is marked other any Injury or other traumatic event after. 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) MOLLIE COHEN 2 DAVID FACKOFF 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 9040 SAFFRON LANE SILVER SPRING, MD 20901 DAVID KOSS 20b. Pface of Disposition (Neme of gemetery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 4 □ Donation 5 □ Other (Specify) ADAT SHALOM MEMORIALPARK 8-26-98 LIVONIA, MI 21. Signature of Funeral Service 22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPEL, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852 Enter the disease, or complications that caused the deat Do not enter the mode of dying, such as cerdiac or respiratory arrest, or beatt failure. List only one cause on each line. Approximate Interval Betw Onset end Death Physician Immediate Cause (Final /Medical CARDIOPULMONARY disease or condition resulting in death? Examiner Due to (or as a consequence of) INFAR CTION ACUTE MYOCARDIAL The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that Initioted events resulting in death) Lest Brid Due to (or as a consequence of) physician the burie Box 68760 Physician/Medical Due to (or as e consequence of): P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 Unknown signed b ACUTE RENAL FAILURE Records, þ 24b. Were autopsy findings available prior to completion of cause of deeth? Be Completed 24e. Was en eutopsy performed? peed page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificata Division of Vital Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certificatal filled in by the funeral director, 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Dev Year) 28c. Injury at Work? 28d. Describe how Injury occurred 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours aft To the Funeral DI completaly filled in Medicai 29a. Certifier 💢 Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and piece, and due to the ceuse(s) end menner as stated. 2 Medical Exeminer: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 8 22 98. M.D. D0052931 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) AL JAWAD WARAS. 11119 ROCKVILLE PIKE, SHITE 100, ROCKVILLE MD 20852 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State Registrar AUG 24 1998

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month onna 25, AUGUST 1998 11:55 AM 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Mary Land 1947/Lansdowne, Days Hours Min. 1 ☐ M 2 🖾 F Months 50 214-44-5197 September 30, Usual Residenca of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes XXNo Maryland Queen Annes Ingleside 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 311 St. Paul Road 21644 U.S.A. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 X Married 1 ☐ Yes 2XXNo Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorcad 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decadent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Law Firm Para-Legal 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Shirley E. Shettle Carl E. McCade, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond G. Krauser/Husband 311 St. Paul Road, Ingleside, Maryland 21644 20b. Plece of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sudlersville CemeteryAugust 29, 1998/Sudlersville, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Fellows, Helfenbein & Newnam Funeral Home, I 130 Speer Road, Chestertown, Maryland 21620 ela that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complice shock, or heart failure. List only one Approximate Intervat Between Onset and Death Squamous cell Cancer of Larynx Immediate Cause (Final disease or condition resulting in death) 3 years pothyroidism Due to (or as a consequence of). Due to (or as a consequence of) 23b. Did tobacco usa contribute to the cause of death? 3 Probably 4 Unknown

Physician /Medical Examiner

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Box 68760.

Division of Vital Records, P.O.

Physician

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Examiner

10a. State

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7 is marked other than "natural", or items 23s or 28a-f show traumatic event, the Mobilial Examiner must be notified at

"natural", or

permit. Pages 1 end 2 should be filed within Department of Heelth and Mental thygiene. Important: If Item 27 Is marked other than "I any Injury or other traumatic event, the Mes-

the Maryland

72 hours after

Saltimore, Maryland 21215-0020

Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting In death) Last Physician/Medical à Completed

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed?

1 ☐ Yes 2 No 1 Yes 2 No 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 5 Pending investigation Naturet 1 ☐ Yes 2 ☐ No 2 Accident 3 Sulcide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of injury - At home, farm, street, factory, office building, etc. (Specify)

4 Homleide 29a. Certifier

Cortifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year) 29c. License number

-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Matthew Kashima 600 North

600 North Wolfe Street Baltimore Maryland 21287

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature AUG 28 1998

MES 28 1838 James H. James

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedant's Name (First, Middle, Last) 2. Date of Death Month Day EUGENE VICTOR LUCAS **AUGUST 10 1998** 11:25 AM 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth CUMBERLAND ALLEGANY SACRED HEART HOSPITAL If Undar 1 Yaer If Under 24 Hrs. 5. Sociel Security Number 7. Aga (In vrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplaca (Stata or Foraign Country) 180 M 2□ F Months Davs Hours Yrs. JULY 4 1915 MARYLAND 83 213-10-5252 Usual Rasidanca of Dacedani 10h Counts 10c. City. Town or Location 10d Inside City Limits 1 Yas 2 No MARYLAND ALLEGANY FROSTBURG 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 21532 U.S. 100 HONEYSUCKLE LANE 12. Was Decedant Ever in U,S. Armad Forces? 1 \$\text{SYas} 2 \subseteq No \\ 1941-\text{Yes, Giva}\\ Year or Dates: \\ 1945\end{array} Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Rece - American Indien. 11 Marital Status Black, Whita, atc. 1 Nevar Married 2 Married 1 ☐ Yes 2 No Specify: WHITE Specify. 3 ☐ Widowed 4 ☐ Divorced 1945 16a. Dacedant's Usuel Occupetion 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highest grade complated) (Giva kind of work dona during most of working life. DO NOT use retired) Elemantary/Secondary (0-12) Collaga (1-4or 5+) BARTENDER BAR 12 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fether's Nama (First, Middla, Last) ANNA (WINNER) LUCAS WILLIAM JAMES LUCAS 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19e. Informant's Name/Ralationship (Type, Print) 44 CENTENNIAL STREET, FROSTBURG, MD 21532 GEORGE L. LUCAS/BROTHER 20b. Place of Disposition (Name of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 X Burial 2 ☐ Crametion 3 ☐ Ramovel from State FLINTSTONE, MD 4 ☐ Donation 5 ☐ Othar (Specify) ROCKY GAP VETERANS CEM. 8/13/98 22. Nama and Addrass of Facilit SOWERS FUNERAL HOME, P.A. 60 WEST MAIN STREET, FROSTBURG, MD 23a. Pert1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batwaan Onsat and Daath Immediata Causa (Final diseesa or condition rasulting in death) Caronann Dua to (or es a consequence of) Congestive Due to (or es a consequence of): Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown

Physician /Medical Examiner

item 27

= 0 permit. Page Department of Important: If any Injury or

Physician

Examiner

Funeral

Director

7 is marked other than "naturel", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after onent of Health and Mantal Hygiene. Int: If Item 27 is marked other than "naturel", or iter

Baltimore, Maryland 21215-0020

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10a. Stata

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Examiner Physician/Medical py Completed Be 10 Certification:

physician and the burial-transit that the death certificate be 88 USB signed by the a page 2 certificata funeral After or Attending aftar deat Director: filled in by

Box 68760, P.O. Division of Vital Records, 24 hours Funeral hours

To the Hosp within 24 hor To the Fune completely fi MJS

State Registrar

edicai

29b. Signature and title of og

Sequantially list conditions, if any, leading to immadiate causa. Entar Undarlying Cause (Diseasa or Injury that initieted events resulting In daath) Last Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 24b. Wera eutopsy findings evailabla prior to complation of causa of daath? 24a. Was an eutopsy 1 Yes 2 No 1 ☐ Yas 2 ☐ No 25. Was case rafarrad to medical axaminar? 26. Placa of Daath (Chack only ona) Hospital: Othar: 4 Nursing Home 5 Residence 6 Othar (Specify) 2 ER/Outpatient 3 DOA 1 Yas 2 No 1 Depatiant 28e. Deta of Injury (Month, Day Year) 28d. Dascribe how Injury occurred 27. Mannar of Deeth 28b. Time of 28c. Injury at Work? 1 Natural 5 Panding 1 Yas 2 No invastigetion 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Straat and Number or Rural Routa Number, City or Town, State) 28e. Plece of Injury - At home, farm, streat, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar es steted.

Medical Examiner: On tha basis of axamination and/or invastigation, in my opinion, deeth occurred at tha tima, date end place, end due to tha causa(s) 29a. Certifier

30. Neme and eddress of person who complated cause of death (Item 23a) (Type, Print)

36766

29c. Licensa number

29d. Data signad (Month, Day, Year)

AUGUST 13 1998

M.D. 920 National Highway Lavale MD 21509 ikram ad it roonal 32. Ragistry's Signatura 31. Dete filed (Month, Day, Yaar) AUG 1

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State of Maryland / Department of Health and Mental Hygiene

				Cer	uncale	f Death		Reg. No.	6-17	Trans.
Dharatatan	1. Decedent's Neme (First, Midd	ile, Last)	The				2. Date of De Month	ath Dey	Year 3. Ti	me of Death
Physician /Medical	William V. Lec	ates					Augu	1 1 1	1998	1923
Examiner	4a Facility Neme (If not institution	on, give street and nun	ber)			4b. City, Town, o	r Location of Deat		of Death	
	PENINSULA REG	IONAL MEDI	CAL CE	NTER		SALIS	BURY	W	ICOMICO	
Funeral Director	5. Social Security Number 214-32-1434	6. Sex AZM 2□ F	7. Age (In yrs. 64	last birthday) _ Yrs.	If Under 1 Ye Months Day			th v. Year)	9. Birthplace (S Country) Mo	
72	Usuel Residence of Decedent									
death with the Maryland one 23e or 28e-f show count be notified at nerel Director	10a. State 10b. County	′	10c. Ci	ity, Town or Loc	cation					ide City Limits
of oto	Md. Wicom	ico	Sa	lisbury	7				11	Yes 2 No
Sire	10e. Street and Number			,	10f. Zip Code	9		10g. Citizen of V	Vhat Country?	
P. wi	1506 Tulip Dr.				2	1804		USA		
d within 72 hours after death with the Maryla glens than 'naturel', or lares 23s or 23s-1 show the Medical Examiner must be notified at completed by Funeral Director	11. Meritel Status 1 Never Merried 2 Mai 3 Widowed 4 Divorced	If Yes, Give	ces? ZONo		Vas Decedent of Yes, specify C	of Hispanic Origin? (uban, Mexican, Pue lo Specify:	Specify Yes or No irto Rican, etc.)	14. Race Blace Specify	e - American Indi k, White, etc.	an,
2 ho	15. Deceder	nt's Education		16a. Decede	ent's Usual Oc	cupation		16b. Kind of Bu	siness/Industry	
pier pier	(Specify only higher Elementery/Secondary (0-12)	est grade completed)	4 m x E . \	(Give k	kind of work do NOT use ret	ne during most of w ired)	orking			
i within liens. The Me	12	College (1-	40r 5+)	Auto M	iechani.	2		Texac	o Co.	
be filed within 72 ho tal Hyglene. d other than "naturn event, the Medical.] Be Completed	17. Father's Neme (First, Middle,	Last)				18. Mother's N	ame (First, Middle	Maiden Sumam	Θ)	
Mental be Mental be served of served of To Be	William F. Lec	ates				Mart	le Mumfo:	rd		
d 2 should be file th and Mental Hy 7 is marked othe traumatic event. To Be C	19a. Informant's Name/Reletions			19b Mailing	Address (Stre	eet and Number or I			State Zin Code)	
47 9 2 2 4 4 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	Elizabeth Ann		ife			Dr. Salis			, -,,	
s 1 and f Health Item 27 other te	20a. Method of Disposition	Becares, A					Date		City or Town, St	ate
semit. Pages 1 ar Department of Hea Important: If Item: Inty Injury or othe Inca.	1 X Burial 2 Cremation 4 Donetion 5 Other (S		tete	Place of Dispos cemetery, crem :- Steph	iens Cer		8-22-98	Delmar		
tificate be assorted as the burishtransit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	5 b	CH	or as a consequ				-24		
	Cause (Disease or Injury that initieted events resulting in death) Last	С	Due to (d	or as a consequ	ence of):					
÷ 0, 0	that initieted events resulting in death) Last	d	`							
÷ 0 0	that initieted events		`			given in Part I.		_	ntribute to the co	
at the death certing by the attending etached for use a Physician/M	that initieted events resulting in death) Last		`			given in Part I.		tobacco use col Yes 2⊡ No	ntribute to the c	
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requires that the death certines seen signed by the attending thould be detached for use a eted by Physician/M	that initieted events resulting in death) Last		`			given in Part I.	1 □	Yes 2 No an autopsy	24b. Were sut available completic	4 Unknow
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N. Tecates

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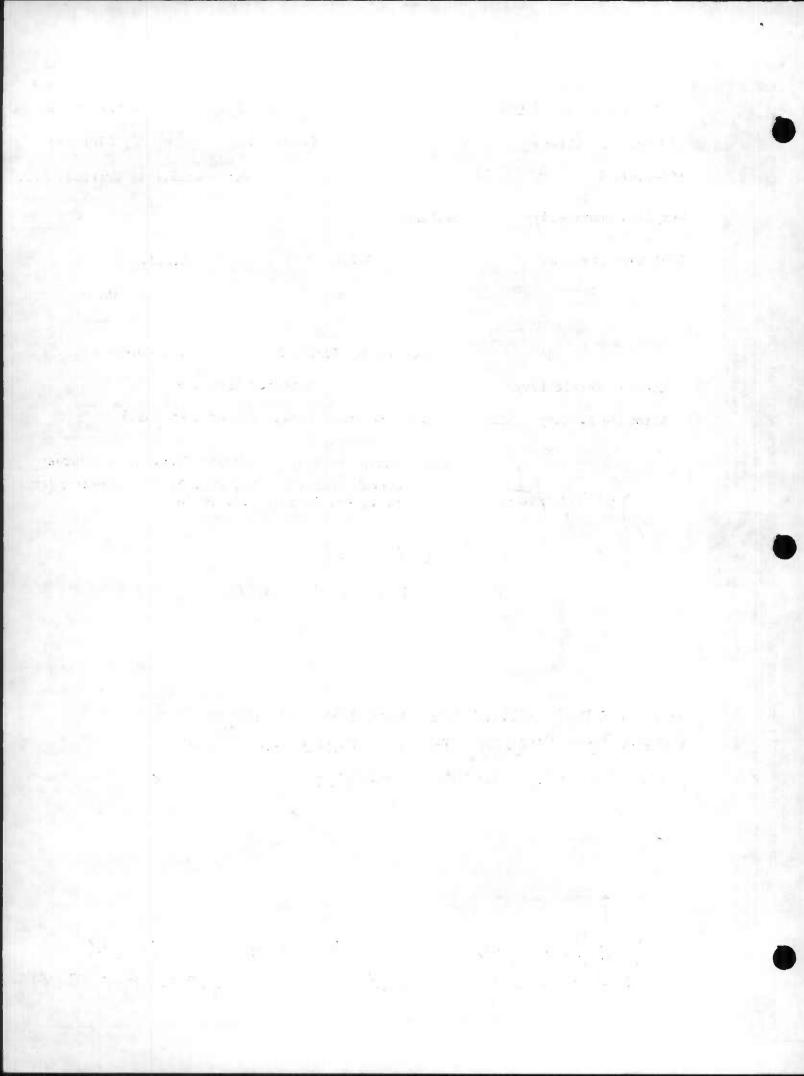
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10F 03 EVA

State of Maryland / Department of Health and Mental Hygiene Amended #8, 8/24/98, Mont. Co., GF Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth 2. Date of Deeth **Physician** 17,1998 9:30 ANI HAROLD AUGUST /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Montgomery Bethesda CARP MANOR If Under 1 Yeer If Under 24 Hrs. 5. Social Security Number 6 Say 7. Age (In vrs. lest birthday) 8. Date of Birth (Month, Dey, Year) 1919 Sirthplece (State of Foreign Country) **Funeral** 17 M 2□ F Months Deys Hours Yrs 78 Director 155-22-1404 December 25, 1914 Trenton, N.J. Usual Residence of Decedent the Maryland 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f ahow Maryland Montgomery Bethesda ty Yes 2 No Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? with 7 is marked other than "natural", or items 23a or traumstic avent, the Medical Examiner must be a 5401 Edgemore Lane Funeral 20814 Pagas 1 and 2 should be filed within 72 hours after death nant of Haaith and Mental Hygiena. 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian 11. Maritel Status Bleck, White, etc. 1X Yes 2 □ No If Yes, Give Yeer or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedant's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) Government Official U.S. Government 18. Mother's Neme (First, Middla, Maidan Sumeme) 17. Fether's Neme (First, Middle, Last) Margaret Rochelle Charles Harold Levy 19b. Meiling Addrass (Street end Number or Rural Route Number, City or Town, State, Zlp Code) 19e. Informent's Name/Reletionship (Type, Print) 5401 Edgemoor Lane, Bethesda, MD 20814 of Haaith a f item 27 is r other tra Veronica A. Levy Wife 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition Important: If its any injury or oth 1 ☑ Buriel 2 ☐ Cremetion 3 ☑ Removel from State 4 □ Donetion 5 □ Other (Specify) 8/22/98 Trenton, New Jersey Ewing Church Cemetery 21. Signeture of Fuheral Service Licensi 22. Neme end Address of Facility Joseph Gawler's Sons, Inc. 5130 Wisconsin Avenue N.W., Washington, D.C. 20016 r the disease, or complications that ceused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, sert failure. List only one ceuse on each line. Approximete Interval Between Onset end Deeth **Physician** CARDIAL ARRES Immediata Causa (Final disease or condition resulting in death) /Medical Examiner Examine physician and the burial-transit The law requires that the death certificate be executed Sequantially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e conseguance of) P.O. Box 68760. Physician/Medical Due to (or es a consequence of) SE 980 signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributa to the causa of death? RHEUMATOID ARTHRITIS, RHEUMATOID WIND 1 Yas 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Wera eutopsy findings eveilable prior to completion of cause of deeth? 'ARKINSON'S DISEASE, CHRONIC OBSTRUCTIVE 24a. Was an autopsy performed? Completed LING DISEASE, PULMONARY EMBOL 1 ☐ Yes 2 ☐ No Hospital or Attending Physician:
 24 hours after death.
 Funeral Diractor: After this certifics letely filled in by the funeral director, 25. Was case referred to medical exeminer? Be 26. Place of Daath (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Rasidance 6 Other (Specify) 1 Yes 2K No 2 27 Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Dey Year) 28h Time of 28c. Injury at Work? Certification: 5 Pending investigation 1 De Natural 1 Yas 2 No 2 Accidant Location (Street and Number or Rurel Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At homa, ferm, street, factory, office building, etc. (Specify) 4 Homicida 29a. Certifier 🔁 Certifying Physician: To the best of my knowladge, daath occurred et the time, date end plece, and dua to the ceuse(s) end mennar es steted. To the Hosp within 24 hor To the Fune completely fi edical 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at tha time, date end piece, end due to the cause(s) end manner stated. (Check only one) 29b. Signeture end title of confifier 29c. License number 29d. Date signed (Month, Dey, Year) of person who complated cause of death (Itam 23a) (Type, Print) RAY AVE. BETHESDA, 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State AUG 24 1998

DHMH 16 Ray 6/95

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Dete of Death 3. Time of Death Day Month Mary Jolyne Lawrence Aug.21,1998 01:15am 4a Facility Name (If not Institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth | Silver Spills | Since of Birth (Month, Dey, Year) | Feb. 24, 1 Holy Cross Hospital Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1□M 2월F Months Yrs. 579-40-7661 66 1932 Indiana Usuai Residenca of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14212 Parkvale Road 20853 United States 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indien. 11. Maritel Status Black, White, etc. 1 □ Never Merried 2 □ Married 1 ☐ Yes 2 No Specify Specify 3 ⊠ Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Eiementary/Secondary (0-12) College (1-4or 5+) Volunteer Coordinator Holy Cross Hospice 18. Mother's Name (First, Middla, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Joseph Louis Farren Helen Mae Anderson 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Christine Lawrence Mills/Daughter 4656 Linthicum Rd., Dayton, Maryland 21036 20b. Place of Disposition (Nama of cematery, cramatory or other place) Aug. 25, 1998 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park Rockville, Maryland Robert A. Pumphrey Funeral Home/Rockville, Inc.

M00198

Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate shock, or hour feilure. List only one cause on each line. 21. Signature Funeral Service Licensee Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in deeth) PULMONARI DAY S Due to (or as a consequence of): mos METASTANO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) CF CARCINONA Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were eutopsy findings evailable prior to 24a. Was an autopsy completion of cause of death? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Yaer) 27. Manner of Deeth 28d, Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural 1 □ Yes 2 □ No 2 Accident 28f. Location (Streat and Number or Rural Route Number, City or Town, Stata) 6 Could not be determined 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homlcide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the ceuse(s) end manner as steted.

2 Medical Examiner: On the basis of exeminetion end/or investigetion, in my opinion, death occurred et the time, date end place, and due to the ceuse(s) end menner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 8/21/98 D17368

Registrar

State

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Physician

/Medical

Examiner

Funeral

Director

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7 is marked other than "naturel; or fler traumatic svent, the Medical Examine.

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Physician /Medical

Examiner

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Division of Vital Records, P.O. Box 68760,

Physician/Medical Examiner

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Tu Baltimore, Maryland 21215-0020

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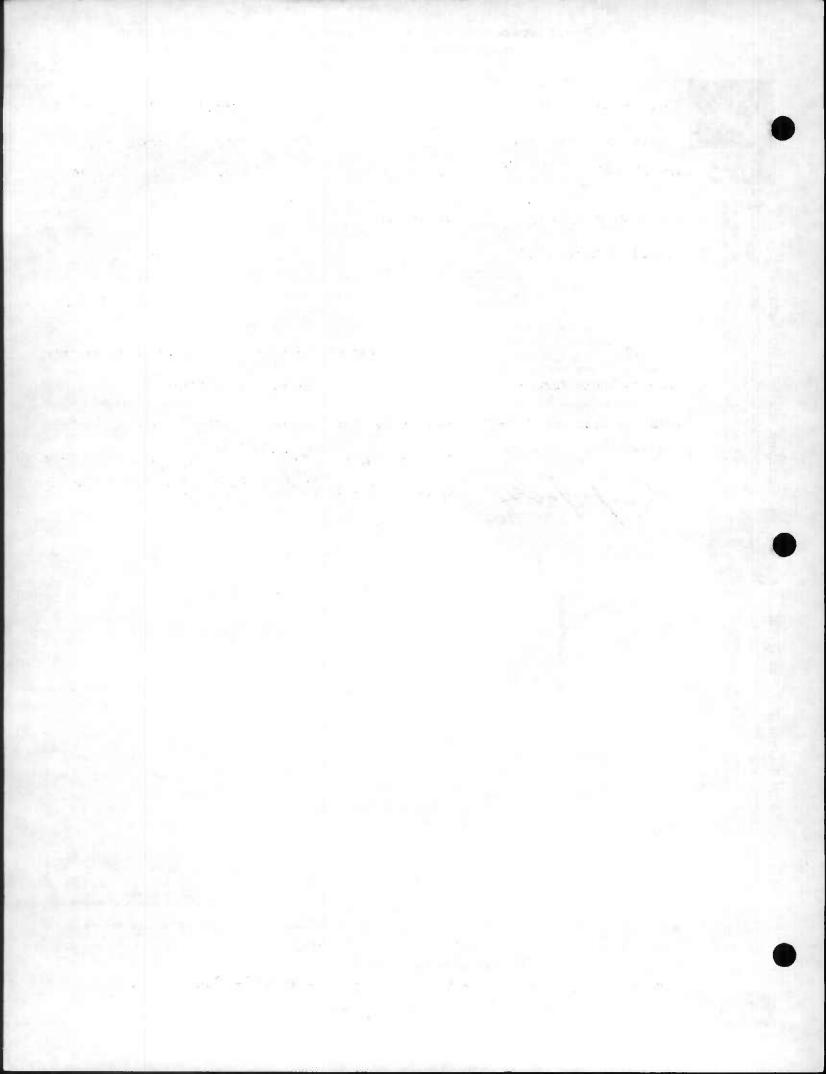
with

death

31. Date filed (Month, Day, Yaar) AUG 24 1998

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

5454 Wisconsin Ave. Chevy Chase, Maryland Stanley A. Schwartz Md 32. Degistrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedant's Name (First, Middla, Last) 2. Data of Death 3. Time of Death Month 08 **Physician** Chance Erdman Lucas ZI 1:00a.m. /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 200 Hadaway Drive Apt. 6D (Residence) Chestertown Kent if Under 1 Year if Under 24 Hrs. 8. Data of Birth (Month, Day, Yaar) Hours Min. August 26, 1922 5. Social Sacurity Number 7. Age (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** M 2□ F 75 216-14-9183 Director Wye Island, MD Usuel Rasidanca of Decedant the Maryland 10a. State 10b. County 10c. City, Town or Location Itam 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Modical Examiner mast be notified at 10d. inslda City Limits Director 1X Yes 2 □ No Maryland Kent Chestertown 10a. Street and Number 10f. Zip Code 10g. Citizan of What Country? 200 Hadaway Drive Apt 6D 21620 U.S.A. Funeral 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☑Nas 2 ☐ No If Yas, Give Yeer or Datas: 1943—1945 Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian. Black, White, etc. hours aftar 1 Navar Marriad 2 Married Baltimore, Maryland 21215-0020 1 Yas 200No Specify Specify: White þ 3 Widowed 4 □ Divorcad Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa ratired) 15. Dacedent's Education (Specify only highest grada completed) 16b. Kind of Businass/Industry permit. Pagas 1 and 2 should be filed within 7 Department of Health and Mantal Hygiena. Important: If item 27 is marked other than 7 any injury or other traumatic event, in the 19. Elamantary/Secondary (0-12) Collaga (1-4or 5+) Correctional Officer State of Maryland 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maldan Surname) Be Bradford S. Lucas Vallie Chance 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Numbar, City or Town, Stata, Zip Code) John Spencer Lucas/Son PO Box 98 127 Walnut Street, Church Hill, Maryland 21623 20e. Mathod of Disposition 20b. Placa of Disposition (Nama of cematary, cramatory or other placa) Date 20c. Location - City or Town, Steta 1 Burial 2 Cramation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Church Hill Cemetery/August 24, 1998 Church Hill, Maryland 22. Nama and Address of Fecility Fellows, Helfenbein & Newnam Funeral Home, 130 Speer Road, Chestertown, Maryland 21620 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, let only one ordine on each line. 23a. Part1. Enter the disease shock, or haart failure. Approximata Intarval Batween Onset end Daeth **Physician** Cardio Rospiratory Awast /Medicai tmmadiata Cause (Finel disaase or condition rasulting in daath) < I day Examiner Dua to (or as a consaquanca of) Physician/Medical Examiner ASCVD The law requires that the death certificate be axecuted Sequantially list conditions, if any, leeding to immediata causa. Entar Undarlying Cause (Disaasa or injury bunal-trar and Dua to (or as a consequence of): Records, P.O. Box 68760, physician thet initiated avants rasulting in death) Last tha Dua to (or as a consequence of) usa as for usa as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 6 SIPPTCH/ HXMI/ HXVF, b Hx Brady condia/ Hx MI Yes 2 No 3 Probably 4 Unknown þ Completed 24a. Was an autopsy parformad? 24b. Were eutopsy findings available prior to the EtOHabuse / Asbostosis / P.V.D. / the Heute Rouel failure completion of cause of deeth? hes Kx HepatitisC Hacivehosis Ha Sovere Dormatitis 1 Yes 2 No 1 Yas 2 No Division of Vital Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this cartificataty filled in by the funeral director. 25. Was casa rafarrad to medical axaminar? Be 26. Placa of Death (Check only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatiant 3 ☐ DOA Othar: 4 ☐ Nursing Homa 5 ₺ Rasidenca 6 ☐ Othar (Specify) 1 Yas 2 No P 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28c. Injury at Work? Certification: 28b. Tima of 28d. Dascribe how injury occurred 5 Panding investigation 1 Natural 1 ☐ Yas 2 ☐ No 2 Accidant 3 Suicida 6 Could not be detarmined 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicida Medical Certifying Physician: To the best of my knowledge, daeth occurred at tha time, date and placa, and dua to tha causa(s) and mennar as statad.

Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at tha time, data and place, and dua to the causa(s) end manner stated. 29a, Cartifiar To the Hosp within 24 hor To the Fune completely fi 29b. Signature and title of certifier 29c. Licansa number 29d. Dete signed (Month, Dey, Yaer) D50996 9 8 30. Name end eddress of person completed cause of death (Item 23e) (Type, Print) + Chastortown UD 21620 Neil Stooddard MD 100 Brown St. 31. Data filad (Month, Day, Year) 32. lagistrar's Signature State AUG 2 4 1998 Registrar

Saring the money spirit of the

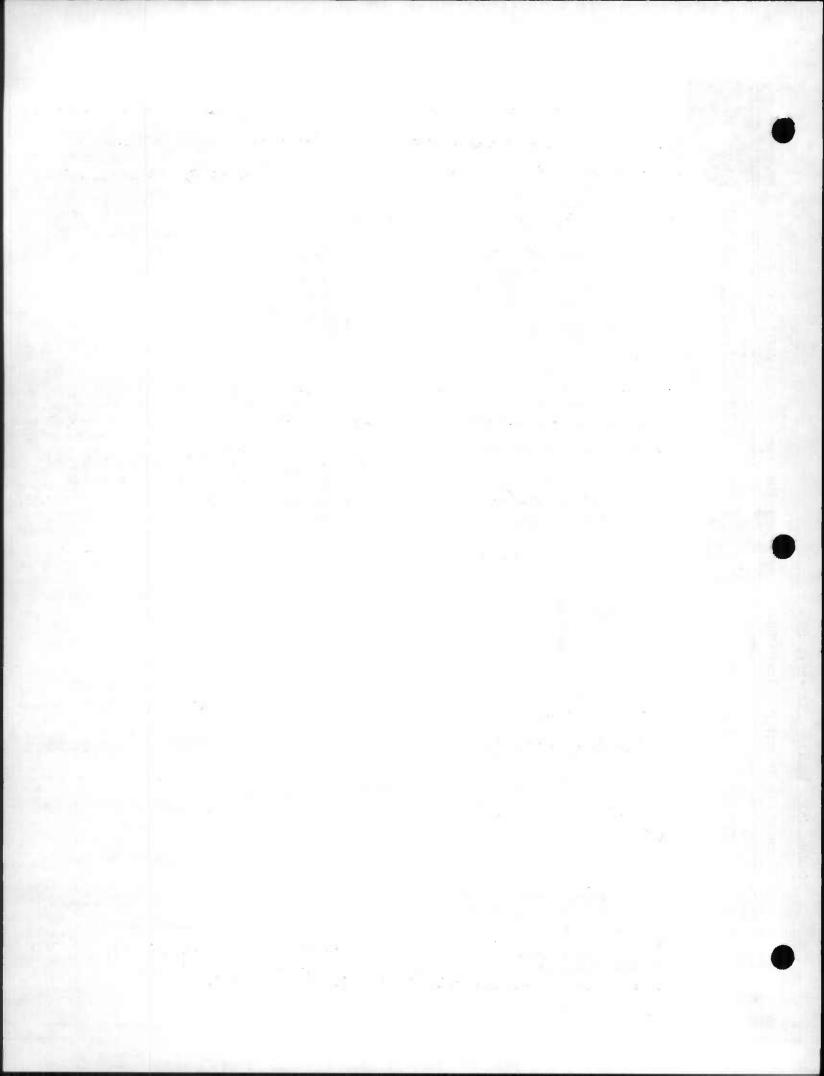
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Harold 4e. Fecility Neme (If not institution, given 14340 Valley Rd.) 5. Social Security Number 8. S. Social Security Number 220–34–2021 Usuel Rasidence of Decedent 10a. Stale 10b. County MD Allegant 10e. Street end Number 14340 Valley Rd. 11. Maritel Status	Sex 7. Age (In 59 10c)	Knig	If Under 1 Year Months Deys			4c. County Alleg	
4e. Fecility Neme (If not institution, given 14340 Valley Rd. 5. Social Security Number 8. S 220-34-2021 Usuel Rasidence of Decedent 10a. Stale 10b. County MD Allegan 10e. Street end Number 14340 Valley Rd	Sex 7. Age (In 59 10c)	yrs. lest birthday) Yrs. C. City, Town or Loc	If Under 1 Year Months Deys	4b. City, Town, or L Cumberlar If Under 24 Hrs.	ocation of Deeth d 8. Date of Birth (Month, De)	4c. County Alleg	of Deeth any 9. Birthpleca (State or F Country)
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MD Allegan 10e. Street end Number 14340 Valley Rd			ation				
10e. Street end Number 14340 Valley Rd	ıy	Cumberlan					10d. Inside City
10e. Street end Number 14340 Valley Rd	-5		d				1 ☐ Yes 2
			10f. Zip Code			0g. Citizen of V	Whet Country?
	1.		2150	12		USA	-
I I . Maillei Status	12. Was Decedent Ever	in U,S. 13. W			acify Yes or No-		e - American Indian,
1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorcad	Armed Forces? 1 ★ Yes 2 No If Yes, Give 11/6 Year or Detes:	1-11/63	Yes, specify Cut ☐ Yes 2 ☐ No	Hispenic Origin? (Sp ben, Mexican, Puerto Specify:	Rican, etc.)		ck, White, etc.
15. Decedent's Ec	ducetion				T	16b. Kind of Bu	
(Specify only highest gra	ade completed)	(Give k	ind of work done	during most of work	ing		,
12	Collaga (1-40r 5+)	Ma	il Carri	ier		US P	ostal Servi
17. Fether's Name (First, Middle, Last))			18. Mother's Nem	e (First, Middle,	Meiden Sumem	10)
Virgil	William	Mil	burn	Phv1	lis	Irene	Ogleba
	Type, Print)			-			
20a. Method of Disposition		0b. Pleca of Disposi	ition (Neme of		1		City or Town, Stele
1 Buriel 2 ☐ Cremation 3 ☐	Removel from State	cemetery, creme	etory or other ple				
					p 0/20/	o Filn	istone, Md.
21. Signeture of Funeral Service Licen	ISOO	4					
Sequentielly list conditions, if eny, leading to immadiate causa. Enter Undertyling Ceuse (Disease or injury that initieted evants resulting in death) Lest	c						
Contribution of the Manager of the Land							
Pan II. Other significant conditions co	ontributing to death but not	resulting in the und	derlying cause gr	ven in Pert I.		/	atribute to the cause of d 3 Probably 4 □ Un
					24e. Wes e	n eutopsy	24b. Were eutopsy find
					perform	ned?	eveileble prior to completion of ceus
							of deeth?
					1 🗆 Y	s 2 No	1 ☐ Yes 2 ☐ No
25. Was cese referred to medical exeminar?	Hospitel:		1	11111	(Check only on	a)	
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	28e. Date of Injury (Month, Day Year	28b. Time of Injury		ork?	28d. Describe ho	w injury occurr	red
27. Manner of Deeth 1 ☑Neturel 5 ☐ Pending	1			Yas 2 No			
1 Neturel 5 Pending 2 Accident Investigation	9		et. factory, office		28f. Location (St City or Town	reet end Numbe o, Stata)	er or Rurel Route Number
1 Neturel 5 ☐ Pending		At home, farm, stree ecify)	.,, , ,				
1 Neturel 2 Accident 3 Suicide 4 Homloide 29a. Ceritier 5 Pending Investigation 6 Could not be datermined	28e. Plece of Injury - A	knowladge, deeth o	occurred et the ti	ma, dete end plece, opinion, daath occurr	end due to the co	euse(s) end ma ete end place, a	nner es stelad. and due to the ceuse(s)
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1	28e. Plece of Injury - A building, etc. (Spi yelclen: To the best of my tiner: On the basis of exam	knowladge, deeth o	occurred et the ti estigetion, in my o	opinion, daath occurr	ed et the time, d	ete end place, a	and due to the ceuse(s) I (Month, Dey, Year)
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1 Neturel 2 Accident 3 Suicide 4 Homlolde 29a. Certifier (Check only one) 29b. Signature and till of certifier	28e. Plece of Injury - A building, etc. (Sp. yslcien: To the best of my niner: On the basis of examend menner steted.	knowladge, deeth onlinetion end/or inversity (Item 23a) (Type, Pr	29c. Licent	opinion, daath occurr	ed et the time, d	ete end place, a	and due to the ceuse(s) I (Month, Dey, Year)
	15. Decedent's Example of the Course of Specify only highest grade the Course of Specify only highest grade the Course of Specify only highest grade the Course of Specify on the Course of Specify	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) Collaga (1-4or 5+) 12 17. Fether's Name (First, Middle, Last) Virgil William 19e. Informent's Name/Reletionship (Type, Print) Linda Milburn (Wife) 20a. Method of Disposition 12 Buriei 2 Cremation 3 Removel from State 4 Donation 5 Other (Specify) 21. Signeture of Fundal Service Licensee 22a. Pert1. Enter the disease, or complications that caused the shock, or heart feilure. List only one ceuse on each line. 12a. Enter Underlying in deeth) Due to the cause of the cause of the cause of the cause. Enter Underlying C. Due to the cause of the caus	15. Decedent's Education (Specify only highest grade completed) 16e. Deceder (Give kilfe. D	15. Decedent's Educetion 16e. Decedent's Usual Occu (Give kind of work down life. DONOT use retin life. DO	15. Decedent's Education 16. Decedent's Usual Occupetion 16. December 16. Decem	15. Decedent's Education 16e. Decedent's Usual Occupetion 16e. Decedent Usual Occupetio	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) 17. Fether's Name (First, Middle, Last) Virgil William Milburn Mi

	Certificate of Death	Reg. No.	
	1. Decedant's Nama (First, Middla, Last)	2. Data of Death Month Day	3. Tima of Death
Physician /Medical	George Francis Mc Dermott	August 19, 1	
miner	4a Facility Nema (If not institution, give street and number) 4b. City, Town, or Loc	cation of Deeth 4c. Cou	nty of Deeth
	Memorial Hospital & Medical Center Cumberland	d Al	legany
ral	5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) If Undar 1 Year If Undar 24 Hrs.	8. Data of Birth	9. Birthplace (State or Foreign Country)
tor	705-05-4406 1MM 20F 92 Yrs. Months Deys Hours Min.	Month, Day, Year)	Maryland
-	Usuel Rasidance of Decedant		
y Funeral Director	10a. Stata 10b. County 10c. City, Town or Location		10d. Insida City Limits
to	maryland Allegany cumberland		1 ØYes 2 □ No
Director	10e. Street end Number 10f. Zip Coda	10g. Citizan	of What Country?
0	604 Frederick Street 21502	US	A
Funerai	11 Marital Status 12, Wes Decedant Evar in U.S. 13. Was Decedant of Hispanic Origin? (Spe	cify Yas or No- 14. F	lace - Amaricen Indian,
Für	1 ☐ Navar Married 2 ☑ Married 1 ☐ Yes 2 ☑ No	Rican, atc.)	Black, White, atc.
by	3 ☐ Widowad 4 ☐ Divorced Yaar or Datas:	Spe	city: white
8	15. Decedant's Education 16a. Decedant's Usual Occupation	16b. Kind of	Businass/Industry
Completed	(Specify only highest grade complated) (Give kind of work dona during most of working life. DO NOT use ratired)	ng	
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		(First, Middle, Meiden Sum	
o Be	George W. Mc Dermott Matilo	la ANN H	leiNT2
Ţ	19a. Informent's Name/Relationship (Type, Print) Wife 19b. Mailing Addrass (Street and Number or Rura		
	D' /- MA A smooth	- / /	1 101 / 7100
	Don's deaw McDermott 20a. Mathod of Disposition 1 Disposition 1 Disposition 1 Disposition 1 Disposition 20b. Place of Disposition (Nama of cemafary, cramatory or other place) 5.5 Poter & Paul 21. Signatura of Funaral Sarvice Licensaa 22. Nama and Addrass of Facility 23. Nama and Addrass of Facility 24. Casure - Stein	Data 200 Location	n - City or Town State
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	4 Donetion 5 Other (Specify) SS- Potor & Paul 2.	2,1998 CUMB	erlowd, Md.
	21. Signatura of Funaral Sarvice Licensaa 22. Nama and Addrass of Facility	FUNPOOL HO	Me 230
once.	Ernest A. Riley, Jr. Baltimore Ave. C	umbonlaus	1 41 2 1500
	23a. Part1. Entar tha disaasa, or complications that causad the death. Do not antar tha mode of dving, such as cardiac o		Approximata
ian	shock, or heart failure. List only one ceuse on each line.		Onset and Death
cai	Immediata Causa (Final		Our Day
er	diseasa or condition resulting in death) a. Sepsis		One Day
5	Dua to (or as a consequance of):		
Examiner	b		
xar	Sequantially list conditions, Dua to (or as a consaquance of): if any, laading to immadiate		
<u>2</u>	cause. Enter Underlying Cause (Diseasa or injury that initialed evants Due to (or es a consequence of):		
edicai	that initiated evants rasulting in death) Lest Due to (or es a consequence of):		
cian/Medicai Examir	d		
an			
Physician	Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.	23b. Did tobacco use	contribute to the cause of death
Phy	Aortic Stenosis	1 1 Yes 2□ N	o 3 Probably 4 Unknow
by F			
	Congestive Heart Failure	24a. Was an autopsy performed?	24b. Were eutopsy findings available prior to
leti	- The second of the second of	penomear	completion of cause of death?
Completed		1□ Yas 2 DN	
			1 Yas 2 No
Be	25. Was casa rafarrad to medical axaminar? Hospital: March 1 March 25 10 10 10 10 10 10 10 1		
ion: To Be Com	TE imparient 20 Envolupation 30 DOA 40 Noting Not	na 5 Rasidance 6 De	
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THE THE	3 ☐ Suicide 4 ☐ Homicide Could not be detarmined 28e. Place of Injury - At homa, farm, straat, fectory, office building, etc. (Specify)	28f. Location (Street and Nu City or Town, State)	imber or Rural Routa Number,
Certification:			
	29a. Cartifiar (Check only (Check only Medical Examiner: On the basis of examination end/or invastigation, in my opinion, deeth occurred at the time, date end place, end of examination end/or invastigation, in my opinion, deeth occurred at the time, date end place, end of examination end/or invastigation, in my opinion, deeth occurred at the time, date end place, end of examination end/or invastigation, in my opinion, deeth occurred at the time, date end place, end of examination end/or invastigation, in my opinion, deeth occurred at the time, date end place, end of examination end/or invastigation, in my opinion, deeth occurred at the time, date end place, end of examination end/or invastigation.	and due to the cause(s) end	menner es steted.
edicai	one) 2 Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, deeth occurred and mannar stated.	ou at the time, dete end place	o, and due to the cadse(s)
M	29b. Signatura and titla of central 29c. Licanse number	29d. Date sig	gned (Month, Day, Year)
	D 33280	August	19 1998
	7 10		
)	30. Nama and addrass of parson who dompleted cause of deeth (Item 23e) (Type, Print) Or. Sunil Gupta, Johnson Heights Medical Building, Cu	nue Suite 10	21502
		moenta, MV	21302
State	31. Data filed (Month, Day, Year) AUG 2 1 1998 32. Registrar's Signature		
gistrar	MOD DI 1000 / July		

705-05-4406

GEORGE MC DERMOTT



State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death Reg No 1. Decedent's Name (First, Middle, Last) 2. Date of Death

3. Time of Death

Physician
/Medical
Examiner

Funeral Director

with the Maryland death

> physician and the buriel-transit 980 by the a signed by t has

10e State 7 is marked other than "natural", or items 23s or 28s-f show traumstic avant, the Medical Examiner must be notified at Director MARYLAND 10e. Street and Number Funeral 11. Maritel Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural". or in-page injury or other traumatic avairable. þ Completed Be an **Physician** /Medical Immediate Cause (Final disease or condition resulting In death) Examiner Examine The lew requires that the deeth certificate be executed Box 68760, Physician/Medical Division of Vital Records, P.O. by Completed To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funeal Director: After this certifica completely filled in by the funeal director; Medical Certification: To Be

SARA KATHRYN McGREGOR AUGUST 16 1998 5:48 A.M. 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SACRED HEART HOSPITAL CUMBERLAND ALLEGANY If Under 24 Hrs. Hours Min. 5. Social Security Number 6. Sax If Under 1 Year 7. Age (In vrs. last birthday) 8. Dete of Birth (Month, Dev. Year) Birthplaca (Stete or Foreign Country) Months Days 1 M 2 F 211 12 7974 Yrs. JULY 13 1916 PENNSYLVANIA Usuel Residence of Decedent 10h County 10c. City. Town or Location 10d. Inside City Limits 1 No Yes 2 No ALLEGANY FROSTBURG 10f. Zip Code 10g. Citizen of What Country? 168 EAST MAIN STREET 21532 U.S. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Bleck, White, etc. 1 □ Never Married 2 □ Married 1 Yes 2 No Specify: WHITE Specify 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondery (0-12) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) RALPH LAMISON TRELLA MILLER 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) NANCY MURPHY / DAUGHTER 281 E. MAIN ST., FROSTBURG, MD 21532 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) RICHLAND CEMETERY 8/18/98 JOHNSTOWN, PA 22. Name and Address of Facility
SOWERS FUNERAL HOME, P.A. 21. Signeture of Funeral Service Licenses 60 W. MAIN ST., FROSTBURG, MD 21532 Pen1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feiture. List only one cause on each line. Approximate tnterval Between Onset and Death MYOCARDIAL INFARCTION 20 MINS Due to (or as a consequence of) 10 YEARS HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of): DIABETES MELLITUS 10 YEARS Due to (or es a consequence of):

Pert It. Other eignificant conditions of	ontributing to death but not res	ulting in the underlying	g cause given in Pert I.	23b. Did tob	ecco use co	ntribute to the cause of death?
				1 🗆 Ye	• 2□ No	3 ☐ Probably 4 ☐ Unknown
				24a. Wes an perform		24b. Were eutopsy findings available prior to completion of cause of deeth?
				1 ☐ Yes	No No	1 ☐ Yes 2 ☐ No
25. Wes case referred to medical			26. Place of De	eath (Check only one)	
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2 5	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 Resider	nca 6 Ott	ner (Specify)
27. Menner of Death 1 ☑ Neturat 5 ☐ Pending 2 ☐ Accident investigation	28e. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe how	w injury occur	Derr
3 Suicide 6 Could not be determined	28e. Plece of Injury - At h building, etc. (Specia	ome, farm, street, fect by)	ory, office	28f. Location (Str. City or Town,	eet and Num Stete)	ber or Rurel Route Number,
	yelclan: To the best of my kno ntner: On the basis of examina and manner stated.					
29b. Signature end title of certifier	geeen lea	news	29c. License number			od (Month, Dey, Year) 17, 1998

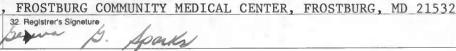
3

State Registrar

AUG 1 9 1998

ANGEL H. ROQUE, M.D.

31. Date filed (Month, Dey, Year)



30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene ()

	- 10-		Decedant's Name (First, Midd	la. Last)	_	Cei	rtificate of	Death	2. Data of De	Reg. No.	, , ,	. Time of I	Dooth
	Physici								Month	Day	Yaar		
	/Medic		Catherine E. M. 4a. Fecility Neme (If not Institution		ber)			4b. City, Town, or L	AUgust ocation of Deet	h 4c. County	1998	05:04	AM
	CXAIIIII	iei	Frostburg Village	Nursing Home	e			Frostburg			legany		
F			5. Social Security Number	6. Sex 7.		. lest birthday)	If Under 1 Yaar	If Undar 24 Hrs.	8. Dete of Bir (Month, De	th	9. Birthplece Country)	(Stete or	r Foreian
	lirector		213-74-4648	1□ M 2⊠ F	95	Yrs.	Months Deys	Hours Min.	27-Jun	-03	Maryla	nd	
aryland	28a-f show	1	Usuel Residence of Decedent 10e. Stata 10b. County		10c. C	ity, Town or Lo	cation					fnsida City	
N N	28a-f	octo		legany	Fro	stburg						1X Yes	2 ∐ No
with t	0 8	ä	10e. Street end Number	Honeysuckle L	ane		10f. Zip Code			10g. Citizen of			
eath	n 23a	eral	11, Maritel Stetus	12. Was Deced	ent Ever in I	16 12 1	215			U.S.A	e - Amarican I	adlaa	
5-0020 72 hours efter death with the Maryland	al', or items Examiner m	by Funeral Director	1 □ Never Married 2 □ Mar 3 ▼ Widowed 4 □ Divorced	ried Armed Forc	es? No		Yas Decedent of P	lispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)		ck, White, etc.	naien,	
21215-0020 d within 72 hours of glena.	natur	Completed	15. Deceder (Specify only highe Elementery/Secondery (0-12)	t's Education st grade completed) College (1-4	lor 5+)			pation during most of work d)	king	16b. Kind of B		ry	
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Maryland d 2 should be file th end Mental Hy	kad o	To Be	William Mansfiel						Broadwat		10)		
laryla 2 should lend	mar		19e. Informent's Name/Relations	hip (Type, Print)		19b. Mailin	g Address (Street	end Number or Rui			Stete, Zip Coo	de)	
1 end 2 Haaith e	127 ls		Beatrice C. Phillp	s Do	aughter	100 Ho	neysuckle Lo	ine Fro	stburg	Mary	land 2	1532-	
Ore les 1	f item		20a. Method of Disposition 1 Burial 2 Cremation	2 Demoved from St		Place of Dispos cemetery, crem	sition (Neme of netory or other place	ce)	Dete	20c. Location	City or Town,	Stata	
limor Pages	ury		4 Donetion 5 Othar (S	pecify)		stburg Mei	morial Park	18	8-Aug-98	Frostburg	, Maryla	nd	
Baltimore, permit. Pages 1 er	any in		21. Signeture of Funerel Service	Duck	1		Neme end Addre	ss of Fecility I Home, 57 F	rost Ave.	. Frostburg	, MD 21.	532	
Phy	sician		23a. Dant1. Entar tha disease, or hock, or heert feilura. List	complications that cau only one cause on eec	sad the daa th line.	th. Do not ante	er tha moda of dyir	ng, such es cardiac	or respiretory e	rrest,	fnta	proximate arval Batw set end Da	veen
/Me	ledical aminer		Immadiata Cause (Final disease or condition resulting in deeth)	e	Lent	Jack	û				1	dan	1
		Jer			Due to (or as a consequence	uence of):				0	one	
cuted	ransit	Examiner	Sequentially list conditions	b. —	Dua to (or es e consequ	uence of):				10	oyer	u
, °	ian ei unal-t		Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events										
68760, ficata be av	physician end is the bunal-transit	dica	thet initieted events resulting in death) Lest	С	Due to (d	or es e consequ	uence of):						
× 6	O1 40	Physician/Medical		d									
Box	attendin for use	clan											
P.O.	the sta	ysk	Pert II. Other significant condition	ns contributing to deat	h but not res	sulting in the un	derlying cause giv	en in Part I.		lobacco use co			
thet D	igned by be detac	by Pt	2 in	the					10	Yes 280 No	3 Probabi	y 4□U	Inknown
SOrc requir	s been sig	Completed b	me	etes						en eutopsy med?		le prior to)
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	cartificate rector, peg		25. Was case referred to medical					26. Piece of Deet			1010	3 2111	
ysici	0 0	2	exeminer? 1 ☐ Yas 2 █ No	Hospitel: 1 🗆 Inpe	atient 2	ER/Outpetlent	3□ DOA Oth	or:		ience 6 🗆 Oth	er (Specify)		
Vision of Vita Attending Physicien: or death.			27. Manner of Death 1 ♣Naturel 5 ☐ Pendin	28e. Dete of I (Month,	njury Dey Year)	28b. Time of Injury	28c. Injur Worl			now Injury occur			
Sio	or: A	catio	2 ☐ Accident Investig	etion				Yes 2□No					
Division Ital or Attending irs after death.	al Director: After tied in by the funera	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	had 286. Piece of	Injury - At he etc. (Specif	ome, ferm, stre	et, factory, office		28f. Location (S City or Tow	Street end Numb vn, Stete)	er or Rural Ro	ute Numb	er,
Div To the Hospital or A within 24 hours after	ne Funer pletely fil	edical	29e. Certifier 1 Certifyin (Check only one) 2 Medical I	g Physician: To the be Examiner: On the basis end menner	s of exemine	wledge, deeth tion end/or Inve	occurred at the tin estigetion, in my o	ne, date end plece, pinion, deeth occurr	end due to the ded et the time, d	ceuse(s) end me dete end plece, o	nner as steted and due to the	l. cause(s)	
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	/	-		A	0			_					
7	2		30. Name and address of person George M. Brez	who completed cause of	of deeth (Item	n 23e) (Type, F	Print) berland. M	aryland 215	02				

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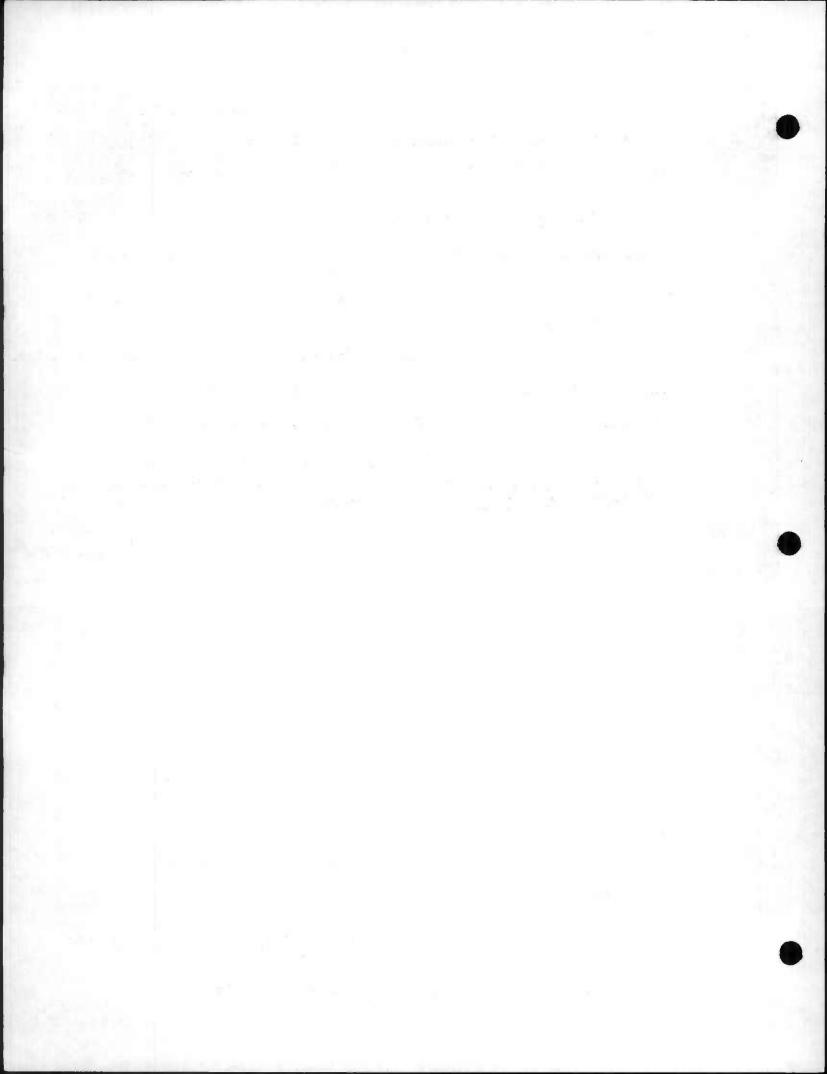
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Examiner	Sacred Heart Hospit	al				Cumberla	nd	Alle	gany		
uneral rector	5. Social Security Number 6. 213-40-2766 Usuel Residence of Decedent	Sex 7. A 1 M 2 □ F	ge (In yrs. lest	birthday) Yrs.	Months Dey				9. Birthple Country Maryla	nce (Stete or Foreign y) nd	n
thow a	10a. Stete 10b. County		10c. City, To	own or Loca	ation				100	d. Inside City Limits	
ecto	Maryland Alleg	any	Mount	Savag	_			40- Chi of N	40	1 ☐ Yes 2 No	
finer must be notified	10e. Street end Number Dutch H	ollow Road			10f. Zip Code 215	45-		10g. Citizen of V			
by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 図 Divorced	12. Wes Decedent Armed Forces 1 Tyes 2 19 If Yes, Give Yeer or Dates:	? No		as Decedent of Yes, specify Co	f Hispenic Orlgin? uban, Mexican, Pu lo Specify:	(Specify Yes or Netro Rican, etc.)	Bled	e - Americer ck, White, et White		
eted	15. Decedent's E (Specify only highest g.	ducetion rede completed)	10	(Give ki	nt's Usuel Occind of work dor	ne during most of w	vorking	16b. Kind of Bu	usiness/Indu	stry	
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Der i	Laura Martin 20e. Method of Disposition	Dave	-		wer Georg	es Creek Lo	naconing	Maryla 20c. Locetion -	and 2		
any injury or other traumatic event, the Money of the Comp	1 Burial 2 Cremetion 3 4 Donetion 5 Other (Spec		ceme	etery, creme	ematory	olace)		Cumberla			
any in	21. Signature of Funeral Service Lion 23e Part 1. Enter the disease, or con	nures	1	Dur	st Funero	Home, 57				532 Approximate	
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		d									
be deteched for use by Physician/	Pert II. Other eignificant conditione			-		-		tobacco use co		the cause of death	
Completed by P	Cere	ter met	lor	aeci	Rent	ory of		s en eutopsy ormed?	evail	e eutopsy findings leble prior to pletion of ceuse eeth?	
Com							1 🗆	Yes 2⊞No	10	Yes 2□ No	
director, page	25. Wes cese referred to medical exeminer?	Hospital:	./			Other:	eeth (Check only				
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shock, or heart failure. L	1/Y. /	11 /11		Donl	Thum an	1 77-	1-50		Churc			- 60
shock, or heart failure. L	or complications	that caused th	e deeth Do			cal Ho			ernpo	ELPI		562 eximete
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	ld not be					165 201		4 4	101			Month
doto	mined 200.	Place of Injury building, etc. (At home, to Specify) 	arm, street, tac	tory, office		28				or Hurei Hould) Number,
Certifier 1 Certify	ying Physician: T	To the best of n	ny knowledge	e, death occurr	red at the ti	me, date and	d place, an	d due to the	cause(s)	and mann	ner as stated.	(-)
(Check only of stands	al Examinar: On	d manner stated	amination ar J.	id/or investigati	lion, in my c	opinion, deal	in occurred	at the time,	date and	piaca, and	d due to the ca	luse(s)
(Check only 2 Medic	ano	\sim			29c. Licens	se number			29d. Date	signed (Month, Dey, Y	ear)
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4	xaminer? Yes 2 No Menner of Death Natural 5 Pen Accident Inve Sulcide 6 Cou Homicide Certifier 1 Certifier (Check only 2 Medic	Yes 2 No Hospital	xaminer? Yes 2 No Menner ot Death Natural Accident Hospital: Certifier (Check only one) Natural Sulcide Germined Yes 2 No Hospital: 1 Inpatient 1 28a. Date of Injury (Month, Day Y 28a. Place of Injury building, etc. (Accident of the determined) 28b. Place of Injury building, etc. (Accident of the determined) Accident Certifier (Check only one) Medical Examiner: On the basis of exand manner stated	Accident Sulcide Certifier (Check only one) Accident with the control of	Accident Certifier (Check only one) Accident one) Certifier (Check only one) Certifier one) Cert	Mospital: Inpatient 2 ER/Outpatient 3 DOA Other Doas	Natural Sulcide Certifier (Check only one) Natural Certifying Physician: To the basis of examination and/or investigation, in my opinion, dear and manner stated. Other: 4 Natural 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Natural 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 Injury M 1 Yes 2 Injury Natural 28c. Injury Natural 1 Yes 2 Injury Natural 1 Yes 2 Injury Natural 1 Yes 2 Injury Natural 1 Yes 2 Injury Natural 1 Yes 2 Injury Natural 1 Yes 2 Injury Natural 1 Yes 2 Injury Natural 1 Yes 2 Injury Natural 1 Yes 2 Injury Natural 1 Yes 2 Injury Natural 1 Yes 2 Injury Natural 1 Yes 2 Injury Natural 1 Yes 2 Injury Natural 1 Yes 2 Injury Natural 1 Yes 2 Injury Natural 1 Yes 2 Injury Natural 1 Yes 2 Injury Natural 1 Yes 2 Injury Natural Injury Natural Yes Injury Yes Injury Natural Yes Injury Yes Yes Injury Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes	Mospital: Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homelener of Death Natural Signature Signature Input Natural Signature Input Signature Inpu	Vas case reterred to medical xaminer? Vas case reterred to medical xaminer? Vas case reterred to medical xaminer? Vas case reterred to medical xaminer? Vas case reterred to medical xaminer? Vas case reterred to medical xaminer? Vas case reterred to medical xaminer? Vas case reterred to medical xaminer? Vas case reterred to medical xaminer? Vas case reterred to medical xaminer? Vas case reterred to medical xaminer? Vas case reterred to medical xaminer? Vas case reterred to medical xaminer? Vas case reterred to medical xaminer to Death (Check only all not Death (Check only year) Vas case year year) Vas case year year Vas case year Vas year Vas case year Vas case year Vas ye	Vas case reterred to medical 26. Place of Death (Check only one) Yes 2 No	Vas case reterred to medical xaminer? Yes 2 No	Vas case reterred to medical xaminer? Yes 2 No



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician JEROME** SAMUEL MOORE August 16, 1998 4:45 PM /Medical 4a Fecility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Salisbury
If Under 24 Hrs. 8. Date of Birth
(Month, Dey, Yeer) Walston Switch Road Wicomico if Under 1 Year 5. Social Security Number 7. Age (In vrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Days Months 1⊠M 2□ F Yrs. Director 216-12-1179 September 10,1919 Maryland Usual Residence of Decedent the Marylend 10c City Town or Location 10a Stete 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Maryland Wicomico Salisbury Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? with 6602 Walston Switch Road 21804 USA death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: WW II Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Building Carpenter Peges 1 end 2 should be filed value of Health and Mental Hygie int: if item 27 is marked other t 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Neme (First Middle Last) Be Samuel Jerome Moore Emma Clara Timmons 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a, Informant's Name/Reletionship (Type, Print) Irene Moore/Daughter 6602 Walston Switch Rd., Salisbury, MD 21804 altimore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 0 1 Buriai 2 Cremation 3 Removal from State permit. Pege Department of Important: if any Injury or once. Wicomico Memorial Park 8/20/98 Salisbury, MD 4 Donation 5 Other (Specify) 22. Name end Address of Facility 21. Signature of Funeral Service Licensee Holloway Funeral Home d the death. Do not enter the mode of dying, such as cardiac or respiratory errest, 23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each Approximate Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Finel tarline watery. MINS disease or condition resulting in death) Examiner Examiner M05 that the death certificate be executed Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last burial-tran end physician mylysmu Physician/Medicai the Due to (or as a consequ USB Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Winknown signed t þ 24b. Were autopsy findings evallable prior to completion of ceuse of deeth? 24a. Wes en eutopsy Completed peen page 2 1 Yes 2 LAN 1 Yes 2 No certificate Division of Vital director, Be 25. Wes cese referred to medical 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Desidence 6 Other (Specify) P 1 -Yes 2 No 1 Inpatient 2 ER/Outpatienf 3 DOA this ierei 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 28a. Date of Injury (Month, Day Year) or Attending 1 Naturel 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours af Funeral Di etely filled in Hospital 1 Destifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the ceuse(s) and menner as stated.

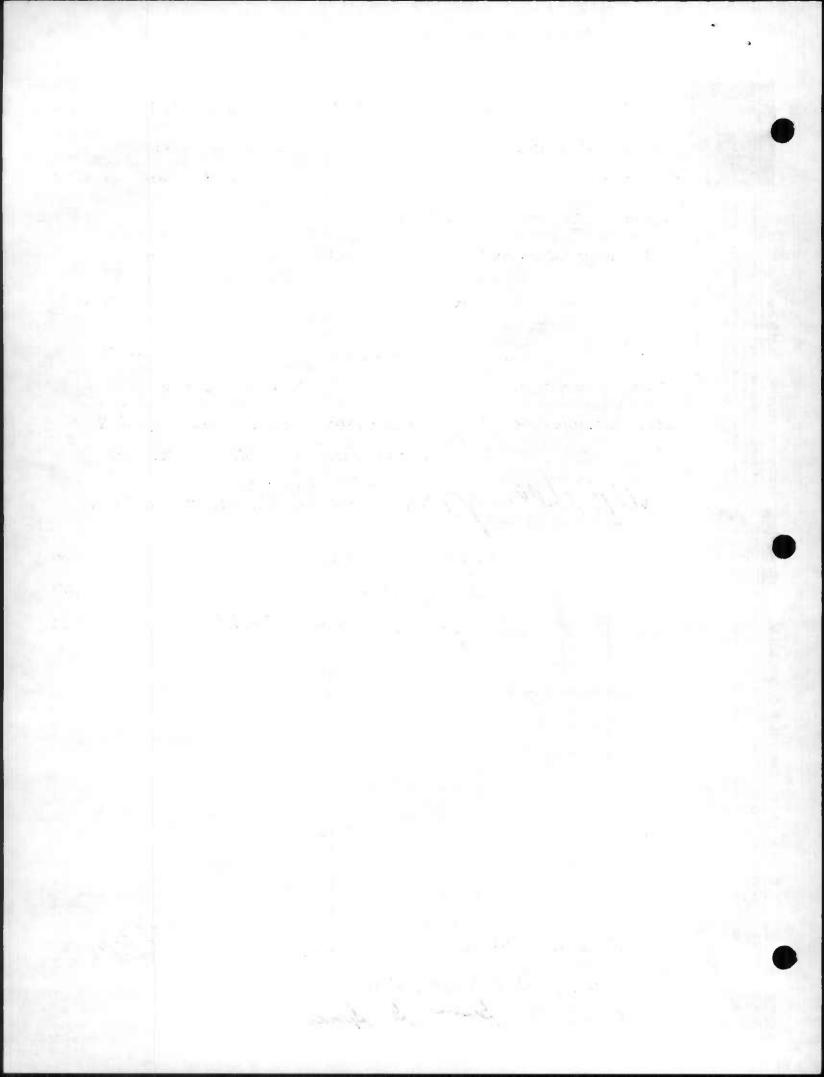
2 Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date and place, and due to the ceuse(s) and manner stated. edical 29a. Certifier (Check only one) To the To the To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Would M 10688 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Mushury POBOX49 DUNALD 31. Date filed (Month, Day, Year) 32. Registrar's Signature

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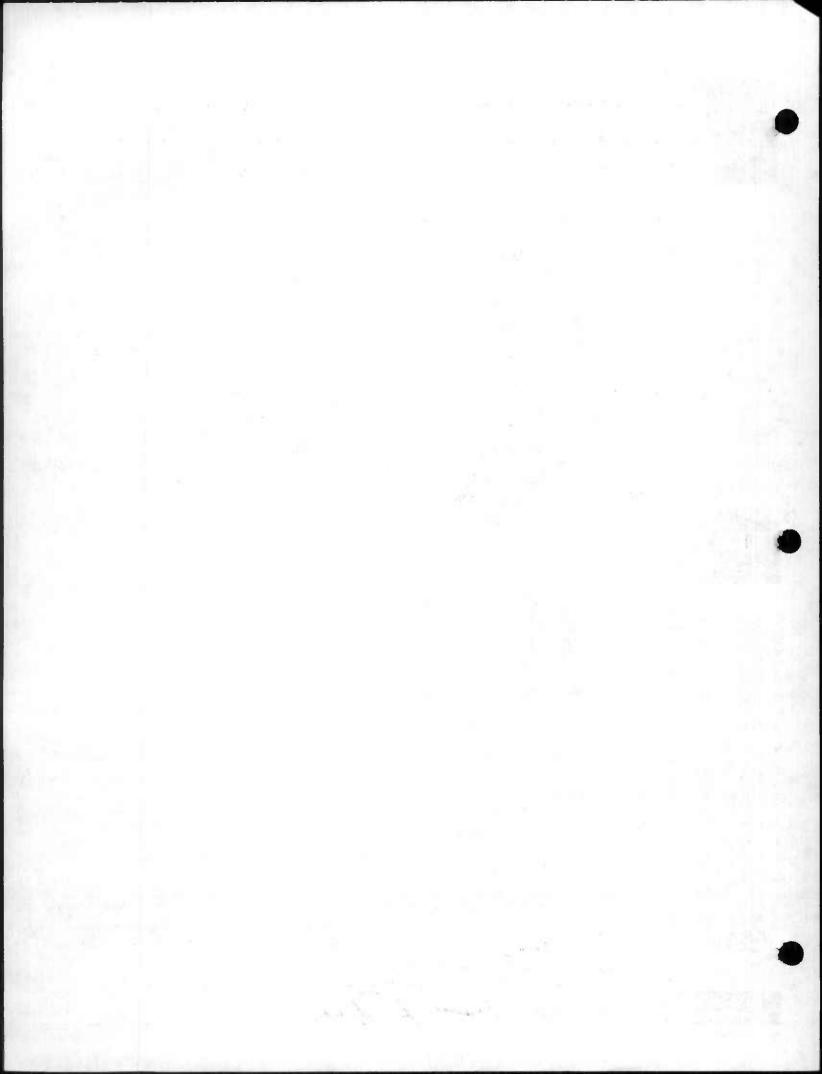
Registrar

AUG 2 1 1998



State of Maryland / Department of Health and Mental Hygiene

					Certific		Death		g. No. 9 8	27432	
Н	Physic	ian	1. Decedent's Neme (First, Middle, Last) CHARLES JOHN McCLOSKEY, JR.					2. Dete of Deet Month	Day Y	3. Time of Death	
	/Med		4e. Fecility Neme (If not institution, give street end num				th Chr. Tourn or I		27, 1998		
	Exami	ner	4970 Battery Lane, #203	161)			4b. City, Town, or L Bethesda	ocation of Deeth	4c. County of		
ore, Maryland 2121	Funeral Director		5. Social Security Number 579-18-6694 6. Sex 1 Months Deys Hours Min. 7. Age (In yrs. lest birthday) 76 Yrs. 7. Age (In yrs. lest birthday) 76 Yrs. 7. Age (In yrs. lest birthday) 76 Yrs. 7. Age (In yrs. lest birthday) 76 Yrs. 7. Age (In yrs. lest birthday) 76 Yrs. 8. Date of Birth (Month, Dey, Year) (Month, Dey, Year) 76 Yrs. 9. Birthplece (Stete or For Country) Washington, 1							Birthplece (Stete or Foreign Country) ashington, D.C	
	pue M		Usual Residenca of Decedent 10e. State 10b. County	10c, City, To	own or Location					10d. Inside City Limits	
	Maryl		Maryland Montgomery Bethesda							1 ☐ Yes 2X No	
	r 28a		10e. Street end Number	Decile		. Zip Coda		. 1	Og. Citizen of Wh	et Country?	
	h wit		4970 Battery Lane, #203			20814			Jnited S		
	72 hours effer death with the Maryland "natural", or frams 23a or 28a-f show added Examinet than be notified at			No Kore	63	ecedent of I- specify Cub	dispanic Orlgin? (Si en, Mexican, Puerto Specify:	pecify Yes or No- Pican, etc.)		American indian, Whita, etc. White	
	2 hou		15. Decadent's Education		6e. Decedent's	Usuel Occup	petion		16b. Kind of Busi		
	within sne.		(Specify only highest grade completed) Elemantery/Secondary (0-12) College (1-4 5+	tor 5+)	(Give kind o lifa. DO NO Examine:		petion during most of worl d)		Maritime J.S. Gov	Administration ernment	
	D = 0 >		17. Fether's Neme (First, Middle, Lest)				18. Mother's Nam	e (First, Middle, M	feiden Sumeme)		
			Charles John McCloskey, Sr.				Myra Calloway				
	d 2 should th and Mer 7 is marke traumatic						eet end Number or Rural Route Number, City or Town, Stete, Zip Code)				
	s 1 and of Health item 27		Joan M. McCloskey/ Wife							ryland 20814	
	00		20e. Mathod of Disposition 1 ☑ Burlal 2 ☐ Cremetion 3 ☐ Removel from St 4 ☐ Donation 5 ☐ Other (Space)		of Hea		August 3:			ity or Town, Stata	
	permit. Peg Depertment Important: It any injury o		21. Signature of Furneral Service Licensee 22. Name end Address of Fecility Robert A. Pumphrey Funeral Home Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenu Bethesda, Maryland 20814-3501								
Physician /Medical Examiner // Cardiac Arrest - Cardiac Arrest - Cardiac Arrest - Ether by dissesse, or complicetions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest. Dethe Sda							st,	Approximete Intervel Between Onset end Deeth			
	2.10	ē	Due to (or es e consequence of):								
rision of Vital Records, P.O. Box	uted d ansit	- Lu	Diabetes Mellitus Due to (or es e consequenca of):								
	lificate be executed g physicien end es the buriel-transit	al Exa	if eny, leeding to Immediate cause. Enter Underfying Ceuse (Diseasa or injury c								
	certificate nding phy use as the	by Physician/Medical Examiner	resulting in death) Last Due to (or es e consequence of):								
	the death cer y the ettendir ached for use		Day II Ohard a March and Miles				Open In Bod I 23h Bliddebases use service to the same at the same				
	thet the death cer led by the ettendin deteched for use		Pert II. Other significant conditions contributing to death but not resulting in the underlying cause				4 🗆 Voc. 2			o use contribute to the cause of death? 2☑ No 3☐ Probably 4☐ Unknown	
	es the		Hypertension, Strokes, Diabetic Gastroparesi			resis		TO FEE ZONO SO FICURION			
	been s		Peripheral Neuropathy					performed? eveileble prior		24b. Wera eutopsy findings eveileble prior to completion of cause of daeth?	
	ysiclan: The law is certificate has director, page 2	Medical Certification: To Be						1 □ Ya	s 2 🖾 No	1 ☐ Yes 2 ☐ No	
	stiffica ctor,		25. Was case referred to medical axaminer?				26. Plece of Deel	h (Check only on	9)		
	To the Hospital or Attending Physicien: Within 24 hours after death Within 24 hours after death Completely filled in by the funeral director,		1 ☐ Yes 2 ☒ No	Copitel: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing			y el k?	fome 5 ☑ Residenca 6 □Other (Specify) 28d. Describe how injury occurred			
			2 ☐ Accident investigetion 3 ☐ Suicide 6 ☐ Could not be determined 28e. Plece of building				281. Location (Street and Number or Rurel Route Number, City or Town, State)				
			29a. Certifier (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one)								
	withir To th		1				ense number 29d. Dete signed (Month, Day, Year)				
	20+1		Chi Water			D.	D26571 August 27, 1998				
			30. Neme and addraba of parson who complated causa of daath (Itam 23a) (Type, Print) Irving Mizus, M.D. 4930 Del Ray Avenue, #301, Bethesda, Maryland 20814								
	Sta	te		ietrer's Signature	,			_,, .			
	Registr	_	AUG 2.8 1998	remen	B.	Loan	61				



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death Dey Month August 25, 1998 4b. City, Town, or Location of Death 4c. County of Death Bethesda Montgomery

Physician /Medical Examiner

Funeral Director

the Merylend r le marked other than "natural", or flems 23a or 28a-f show traumatic event, if a Magical Examinal must be notified at

death 72 hours efter permit. Pages 1 end 2 should be filed within 721 Depertment of Health end Mental Hygiene. Important: if item 27 ie marked other then "nate any injury or other traumatic event, its Magical ance.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

certificate be executed physician and s the buriel-trensit Box 68760. 98 attending use thet the death ed by the a Ö 0 The law requires peen certificate has Division of Vital Physicien: this funeral After Attending efter deeth.

Director: Aft
d in by the fur n 24 hours efter dee Ne Funeral Director pletely filled in by the ò To the Hosp within 24 hor To the Fune completely fi

1. Decedent's Name (First, Middle, Last) Alexander A. McDonald 2:00 PM 4a Facility Name (If not institution, give street and number) Mariner Health Care of Bethesda 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 181M 2□ F Months Days Hours Min Yrs. 578-36-0195 67 Oct. 3, 1930 Canada Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Bethesda Maryland Montgomery Direct 10a Street and Numbe 10f. Zip Code 10g. Citizen of Whet Country? 4949 Battery Lane #322 20814 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 N Married 1 Yes 2 No Specify: Specify: à 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Owner Ice Company 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Neme (First, Middle, Last) Joseph William McDonald Agnes Gertrude Gilsky 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Joan P. McDonald/Wife 4949 Battery Lane #322, Bethesda, Maryland 20814 20b. Place of Disposition (Name of cemetery, crematory or other place) Aug. 26, 1998 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc. Bethesda, Maryland Robert A. Pumphrey Funeral Home/Bethesda-Chevy 7557 Wisconsin Avenue Chase, Inc. Bethesda, Maryland 20814-3501 21. Signature of Funeral Service Licensee 10 M00198 23a. Part1. Enter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsis Due to (or as a consequence of): Examiner Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in death) Last Due to (or as a consequence of): Physician/Medicai Due to (or as a consequence of). Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Hepatic Failure, Cirrhosis, Pancreatitis, by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? Completed Peritonitis, Respiratory Failure 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify) 2 1 Tyes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 1 Neturel 5 ☐ Pending

15 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) end menner as steted.
2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) manner stated. (Check only one) 29b. Signature end title of certifier

2 Accident

4 ☐ Homicide

3 ☐ Suicide

29a. Certifier

29c. License number

29d. Date signed (Month, Day, Year)

281. Location (Street and Number or Rural Route Number, City or Town, State)

D03581

1 Yes 2 No

August 26, 1998

30. Neme end eddress of person ho completed cause of death (Item 23e) (Type, Print)

9410 Old Georgetown Road, Bethesda, Maryland 20814 Elliot R. Goldstein, M.D. 31. Date filed (Month, Day, Year)

State Registrar

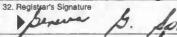
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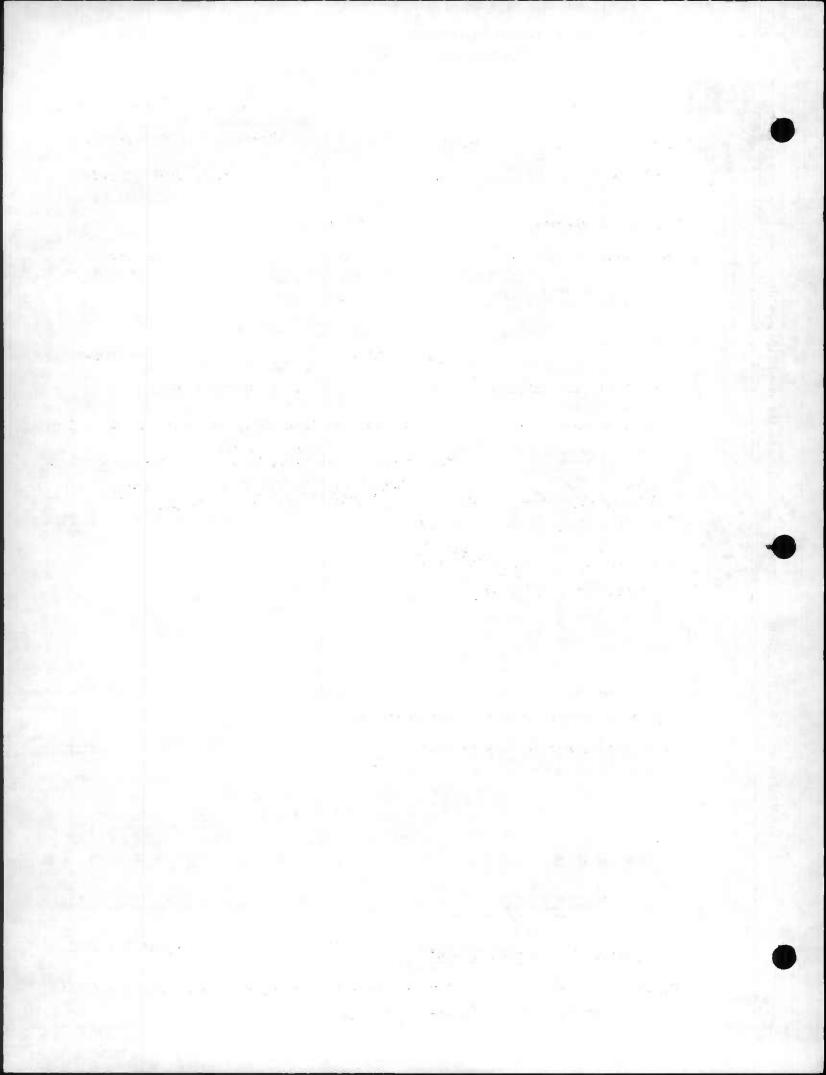
AUG 2 8 1998

investigation

6 Could not be determined



28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Dey 12:30 AM Mary Margaret Mills August 20, 1998 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death 9 Cold Spring Court Potomac If Under 24 Hrs. Montgomery Birthplece (State or Foreign Country) 5. Sociel Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 1□ M 2X F Days Hours Min Yrs. 37 214-58-3612 Feb. 20, 1961 Washington, DC Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ♥ Yes 2 No Delaware Suffolk Lewes 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? J-12 Love Creek 19958 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 💆 No 14. Race - American Indien. 11. Meritel Status Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 ☐ Never Married 21X Married If Yes, Give Year or Detes: 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementery/Secondery (0-12) 12 Stables | Equestrian Specialist 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Charles R. Wolfe Margaret Barrett 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 9 Cold Spring Court, Potomac, Maryland 20854 Margaret B. Wolfe / mother 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) August 24, Dete 1998 20c. Location - City or Town, Stete 20e. Method of Disposition 1 X Buriel 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Gate of Heaven Cemetery Silver Spring, Maryland 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Rockville, Inc. nullen Faurence Darbora -300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Pert1. Enter the divease, or complications thet ceused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death Immediate Ceuse (Finel diseese or condition resulting in death) Malignant Melanoma, Metastatic 1 year Due to (or es e consequence of) Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Due to (or es e consequence of) 23b. Did tobecco use contribute to the cause of deeth? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were eutopsy findings eveilable prior to 24e. Wes en eutopsy completion of cause of deeth? 1 ☐ Yes 2 🕅 No 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical exeminer? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Mother (Specify) Residence Hospital: 1 ☐ Yes 2 🕅 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Yeer) 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 Neturel 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 6 Could not be determined Location (Street end Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 - Homicide 29e. Certifier 110 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and manner as stated 2 1 Medicat Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the (Check only Medicat Examiner: On the basis of exemination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manney stated.

29c. License number

DC4811

29d. Date signed (Month, Dev. Year)

August 25, 1998

Examiner Examiner physician end the buriel-transit that the death certificate be executed Box 68760, Physician/Medicai 89 for use es ad by the e o signed by t Records, p The law requires bluods Completed page 2 hes certificate Division of Vital or Attending Physician; Be To this funeral Certification: After To the Hospital or Attendit within 24 hours after death.

To the Funeral Director: All completely filled in by the fu death.

Physician

/Medical

Examiner

10e Stete

Directo

Funeral

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Completed

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Funeral

Director

the Merylend

permit. Peges 1 end 2 should be filed within 72 hours effer deeth with the Merylei Department of Health end Mental Hysiene. Important: if items 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other treumatic avent, the Medical Examine must be notified an once.

Physician /Medical

Baltlmore, Maryland 21215-0020

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) State Registrar

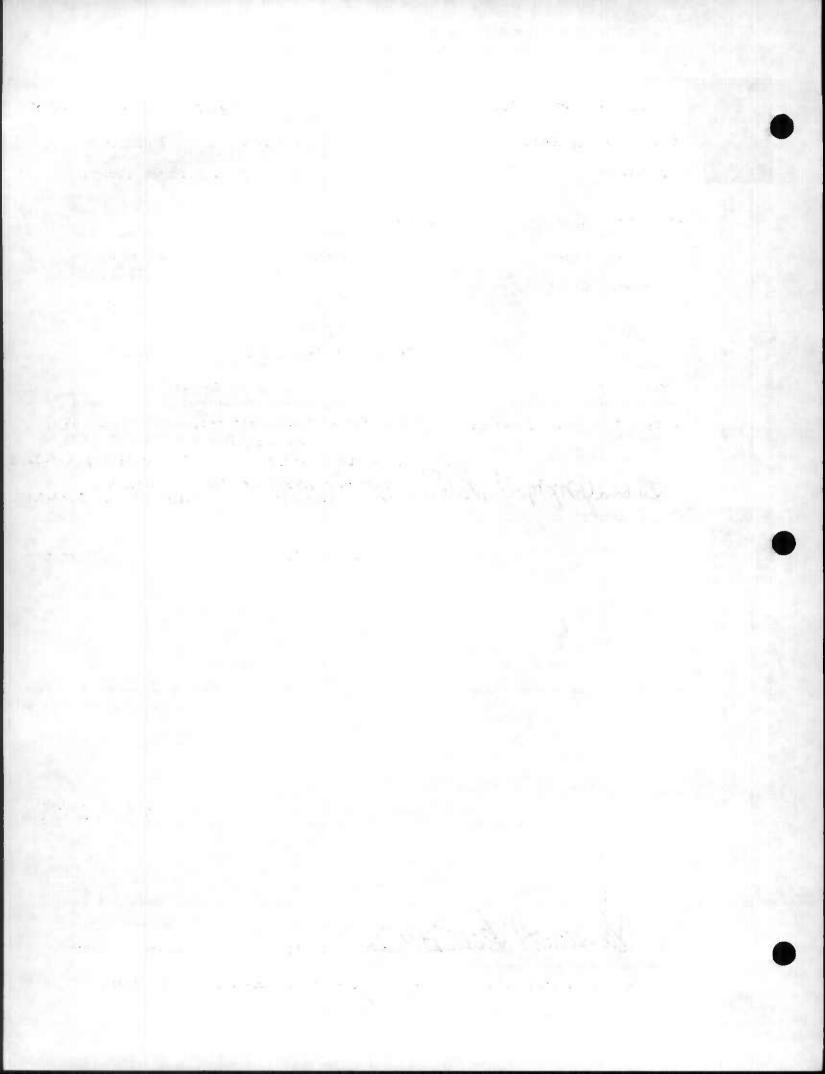
29b. Signature

Lawrence S. Lessin, M.D. 31. Dete filed (Month, Dey, Yeer)

AUG 2 6 1998

en service X

110 Irving Street, N.W., Washington, DC 20010 32. Registrer's Signature

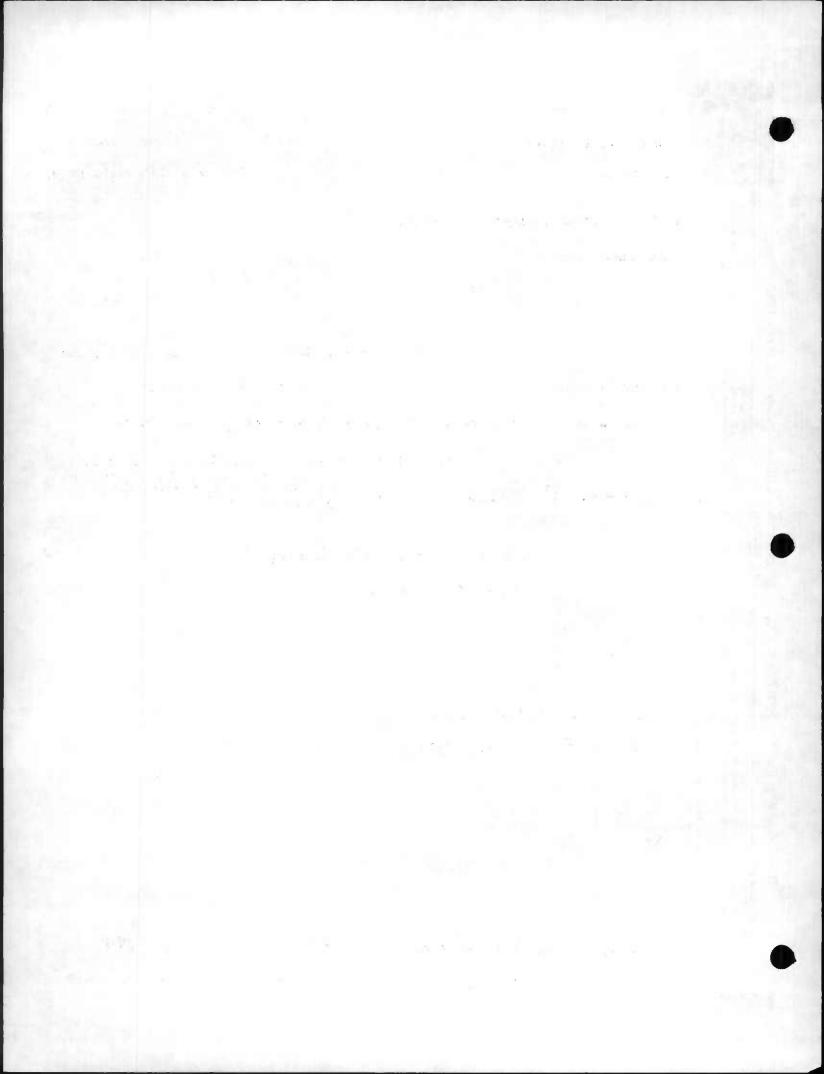


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State of Maryland / Department of Health and Mental Hygiene

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	che						Genevi	eve L. O	' Connor		
19e. Informent's Neme/Releti		ne Print)		19h Mailir	no Address	S (Street			per, City or Town,	State Zin C	Code)
Joan D. Galle											000)
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4 ☐ Homicide det	ermined	building	, etc. (Specil	fy)	reet, rector	y, Offica				or or riarar	riodio ridilibor,
(Check only 2 Medi	fying Phys cal Examin	ician: To the be er: On the basi	st of my kno s of axamina	wledge, death ition end/or in	h occurred vestigation	et the tir	ne, date end ple pinion, deeth oc	ce, end due to the curred et the time	ceuse(s) and me , date end placa,	end due to t	ted. tha cause(s)
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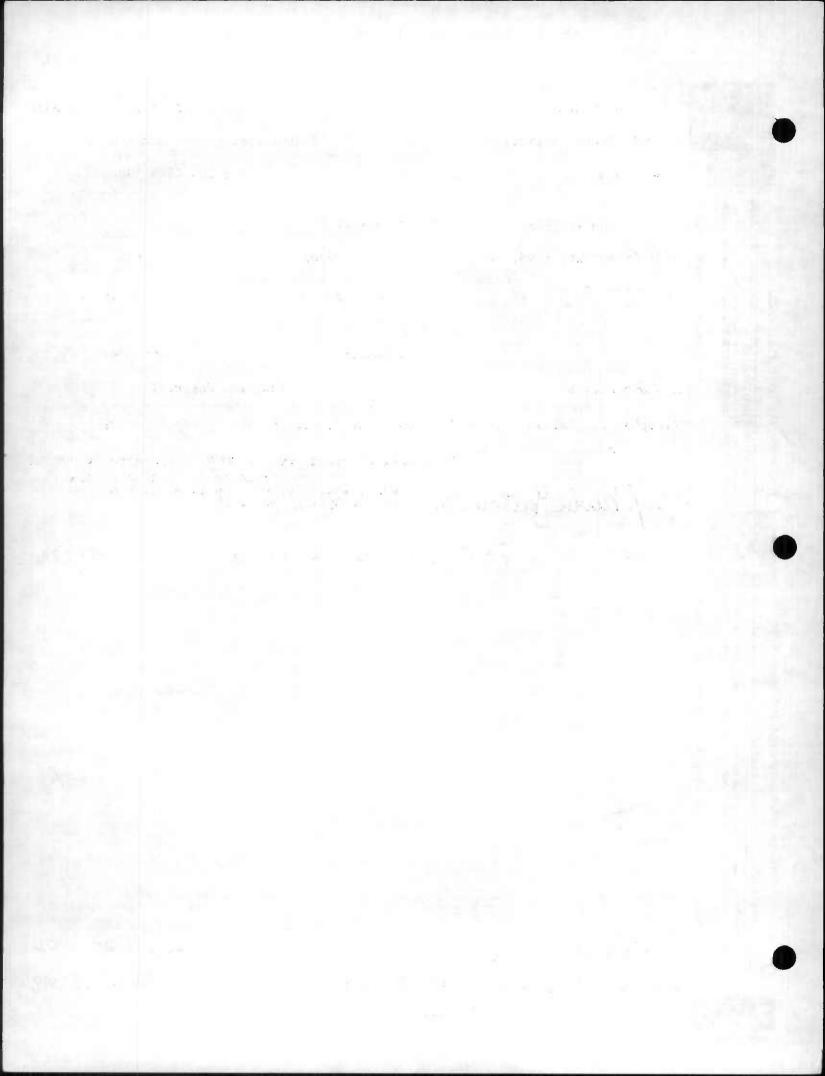
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State of Maryland / Department of Health and Mental Hygiene

9	8	2	7	13	3	6	

				Certifica	ate of	Death		1	Reg. No.		
	1. Decedent's Name (First, Middle, I	ast)						2. Dete of Dee		Voor	3. Time of Deeth
hysiçian /Medical	Marion Mottur								25, 199	98	12:00AM
icai niner	4e Fecility Neme (If not institution, g	ive street and number	7)			4b. City, To	wn, or Lo	cation of Deeth			
	Holy Cross Ho	spital				Silve	er Sp	ring	Mon	tgome	ry
1			ge (In yrs. lest bin		der 1 Yeer	If Under	24 Hrs.	8. Dete of Birt (Month, De		-	plece (Stete or Foreign ntry)
	125-30-5605	1□M 2⊠F	79	Yrs. Month	s Deys	Hours	Min.	May 30	1919	Gree	
	Usuel Residence of Decedent							,			
	10a. Stete 10b. County		10c. City, Town	n or Location						1	Od. Inside City Limits
Director	MD Montgon	nerv	Silv	er Spr	ino						1 ☐ Yes 2 ☒ No
	10e. Street end Number			1	Zip Code				10g. Citizen of	Whet Cour	ntry?
i	1131 University	Rlvd West			200	902			,	JSA	
	11. Marital Status	12. Was Deceden		13. Wes De			igin? (Spe	ecify Yes or No-		e - Americ	cen Indian,
	1 ☐ Never Married 2 ☒ Married	Armed Forces		If Yes, s	pacify Cub	an, Mexicar	n, Puerto	Rican, etc.)	Bte	ck, White,	etc.
	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Yeer or Dates		1 ☐ Yes	2 X No	Specify:			Specif	y: Wh	ite
	15. Decedent's	Education	16e.	Decedent's U	sual Occur	petion			16b. Kind of B	usiness/In	dustry
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	Anthony Hiotis					U	lasi1	iki Pat	eraki		
	19a. Informent's Name/Reletionship	(Type Print)	19h	Melling Addre	ess (Street				er, City or Town	Stete Zir	Code)
	Xenophon Nicolai							er Spri		0.00	
	20e. Method of Disposition	uis (nepi	20b. Plece of	Disposition (#	verne of		SILV	Dete Dete	20c. Location	209 - City or To	
	1 ☐ Burial 2 ☐ Cremetion 3		cemeter	y, cremetory o	r other pla	,					
	4 Donetion 5 Other (Spec		Metro	politan							Virginia
	21. Signeture of Funeral Service Lic	ensee	1	Home.					Colling Blvd.		
	of heren	Yutou	ske.			ring,		20901	DIVU.	WESL	
	23a. Part Enter the diseese, or co	inplications thet cause	ed the deeth. Do r					or respiretory e	rrest,	1	Approximate intervel Between
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		*			4					Onset end Deeth
	Immediate Ceuse (Finat diseese or condition	Q no	2 Jans	21110	(Vise	01/	0			5 years
	resulting in deeth)	е	Due to (or es e	consequence				~~			o gravas
5											
CAGIIIIII	Sequentially list conditions	b	Due to (or es e o	consequence of	of):						
	Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury										
	that initieted events	C	Due to (or es e o	onsequence o	f):						
	resulting in deeth) Lest									t	
an monical		d									
	Pert II. Other significent conditions	contributing to death	but not resulting tr	the underlyin	a cause oi	ven in Pert i	1.	23b. Dld	lobacco use co	ontribute to	o the cause of death?
rugalcian		•	•					10	Yes 20 (No	3 □ Pro	bably 4 Unknown
									-74.0		
d by								24e. Wes	en eutopsy		ere eutopsy findings
Completed								perfo	rmed?	CO	railable prior to empletion of cause deeth?
1									×.		./
								10	Yes 2 2 No	11	Yes 200 No
	25. Wes case referred to medical exeminer?	Hospitel:			- CH	her:		(Check only o			
	1 Yes 2 No	1 Linpai			DOA		7		dence 6 Ot		fy)
ĺ	27. Menner of Deeth 1 SalNeturel 5 ☐ Pending	28e. Dete of In (Month, D		rime of njury	28c. Inju Wo			∠80. Describe	how injury occu	Den	
	Accident Investigati			М	1	Yes 2					
	3 ☐ Suicide 6 ☐ Could not determine	d 28e. Place of II	njury - At home, fa etc. (Specify)	rm, street, fact	ory, office			28f. Location (: City or Tox	Street end Num vn, Stete)	ber or Run	al Route Number,
		3.		5		ale are					
	29a. Certifier 1 Certifying F	hysician: To the bes	t of my knowledge	, death occurr	ed et the ti	me, dete en	nd plece,	end due to the	ceuse(s) end m	enner es s	steted.
	one)	end manner s		GO HIVESTIGAT	on, in my (opinion, dec	JATE OCCUPI	ou or the lime,	uste snu place,	, and due t	oo cadao(a)
	29b. Signeture end title of certifier				29c. Licens	se number			29d. Date sign	ed (Month,	Day, Year)
	RAANDO	42011			DOO	52381			Aunu	£ 48	5, 1992
	30. Neme end eddress of person wh	completed cause of	deeth (Item 23e)	Type Print)					100		
	ROBUNG & AND	CPO FIA		Forest	CO	211 1	ma	1 Soli	VI SO	núl	ms 209/i
	31. Dete filed (Month, Day, Year)	32. Regis	trar's Signeture	TO GOAY	00	4	Turk		-1 -	- 4	1-07
e	AUG 26	1998	renewa	4	los	11.					
rar	ס א מטא	1000	-	1.	More	10/					

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State of Maryland / Department of Health and Mental Hygiene

										f Death		Reg. No.		- 1701
1	Physici		Decedent's Name (First, Middle, L MARY ANN HELEN								2. Dete of Month	Dey	Yeer 8	3. Time of Deeth 2:30PM
	/Medio Examir		4e Fecility Neme (If not institution, g.	ive street and nu	m <i>ber)</i>				_	4b. City, Town, o				
A	LAGITIN	ICI	SUBURBAN HOSPIT	AL						BETHESD	A	MON	TGON	ŒRY
	Funeral Director		158-03-0314	Sex 1□M 2X F	7. Age	(In yrs. last i	birthday) Yrs.	If Und	der 1 Yea			Birth Dey, Year)	9. Birth	pplece (State or Foreign intry) EW JERSEY
	pue *		Usuel Residence of Decedent 10a. State 10b. County			10c. City, To	wn or Lo	cation					T	10d. Inside City Limits
	he Maryle	ector	MD PRINCE G	EORGES		HYAT		LE				100000000000000000000000000000000000000		1 ☐ Yes 2 No
	ath with t	Funeral Director	10e. Street end Number 6909 21ST AVENU	_					Zip Code	20783		10g. Citizen of V	A	
21215-0020	hours after death with the Marylend turet, or items 23s or 28s-f show	by	11. Maritet Status 1 XNever Married 2 Married 3 Widowed 4 Divorced	12. Wes Dec Armed Fo 1 Yes If Yes, Gir Year or D	2 X No	ver in U,S.				f Hispenic Origin? uban, Mexican, Pu to Specify:	(Specify Yes or erto Rican, etc.)	No- 14. Rec Blac Specify	k, White	ican tndien, e, etc. HITE
2-0	72 hours	ted	15. Decadent's l	Education		16	Se. Deced	ent's U	suel Occ	supetion	vorking	16b. Kind of Bu	isiness/l	ndustry
21		nple	Etementary/Secondary (0-12)	Cotlege ()	life. L	OO NOT	use reti	ne during most of v ired)	VOINIII			
	Hygien Hygien out, Its	(Specify only highest (Specify only highest 12) Etementary/Secondary (0-12) 1 2 17. Fether's Name (First, Middle, L					SI	ECRE	TARY	-		VITRO		RP
Maryland	should be filed with ad Mental Hygiene. marked other than matic event, Italy	15. Decadent's (Specify only highest Elementary/Secondary (0-12) 12 17. Fether's Name (First, Middle, Lite SALVATORE MULL 19e. tnforment's Name/Reletionshi MARGARET PATTE: 20a. Method of Disposition									lle, Meiden Sumem	0)		
S	should and Men marke umatic									LOMA				
Mai	2 9 8				D T 1731							nber, City or Town,		ip Code)
	f Health Hem 27 other to		MARGARET PATTER 20a. Method of Disposition	SON (F)	RIEN	-				AD ROAD,	BOWLE,	MD 20720 20c. Location -		Town State
Baltimore	0 1 0		1 🕅 Burial 2 ☐ Cremation 3 4 ☐ Donetion 5 ☐ Other (Spec		State	20b. Place came				nece) IETERY		B BRENTWO		
Balt	permit. Pa Departmen Important: any injury otice.		21. Signature of Funeral Service Lice	Fine	- 3.		HC	ME,	INC	dress of Fecility F C. 500 U PRING, MD	NIVERSI	J. COLLIN		
	Physician		23a. Pert1. Enter the quease, or conshock, or heart to tre. List only	mplications thet of yone ceuse on e			o not ente	er the m	ode of d	lying, such es card	liac or respirator	errest,		Approximete tntervel Between Onset end Deeth
	/Medicai Examiner		tmmediate Ceuse (Final diseese or condition resulting in death)	е		epti								2 weeks
В	B 9	Examiner	(Apr. 1)	b	hre	MIC	e conseq	I M	ph	ocytiz	Leu	kemie		9 years
0,	be swouted loan and burial-transit	Exar	Sequentially tist conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events		D	ue to (or es	e conséq	uence d	ø):	,			į	
68760,	g phys	Medica	that initiated events resulting in deeth) Lest	0.	Di	ue to (or es	e conseq	uence c	f):					
Box	attendir for use	Physician/M		d									1	
0.	the at	S	Pert It. Other significant conditions	contributing to d	leath but	not resulting	in the ur	ndertyin	g cause	given In Pert I.	23b. D	id tobacco use co	ntribute	to the cause of death?
Jan.	s that the de ned by the a e detached	by Phy									_ 1	□ Yes 2□ No	3 🗆 Pr	obably 4 Unknown
Records,	aw requires that as been signed? 2 should be del	Completed b	24									es en eutopsy erformed?		Nere eutopsy findings evailebte prior to completion of cause of deeth?
	iclen: The law certificate has nector, page 2	Com									1	☐ Yes 2 No		I □ Yes 2 □ No
of Vital	iclan: certific nector,	Bec	25. Was case referred to medical examiner?								Death (Check on	ly one)		
1	2 00	To	1 ☐ Yes 2 🕅 No	Hospitel: 1 🛚	Inpatien	t 2 ER/	Outpetien	t 3□	DUA		1	esidence 6 Oth		oify)
vision o	Affect	tification:	27. Menner of Deeth 1 Naturet 2 Accident New York		of Injury oth, Day	Year) 28t	Time of Injury	М	28c. tr V	njury et Vork? □ Yes 2 □ No	28d. Descri	e how injury occur	red	
ivis	r Attend fre-deat frector: n by the	rtific	3 Suicide 6 Could not determine	Z00. PIECE	e of tnjur ling, etc.	y - At home, (Specify)	farm, str	eet, fact	ory, offic	ce	28f. Locatio City or	n (Street end Numb Town, State)	er or Ru	rel Route Number,

29a. Certifier (Check only one)

10x Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examtner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) and menner stated.

29b. Signature and alle of

29c. License number 29d. Date signed (Month, Day, Yeer)

D5-2382

Ruckledge Dr. #620 Bethesda, Mid

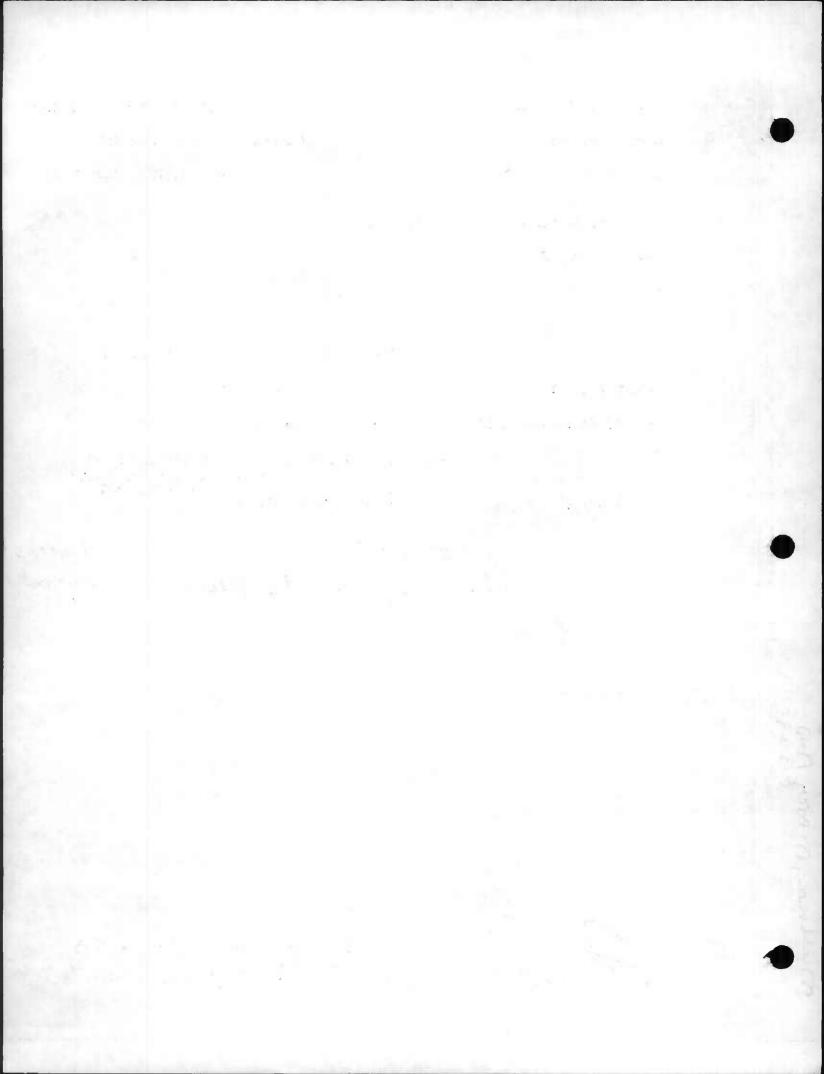
State Registrar

31. Date filed (Month, Day, Yeer)

AUG 25 1998

me and editions of person who completed cause of deeth (Item 23e) (Type, Print)

Doning (410) 32. Registrer's Signature



Please Type or Print in Black Indelibie Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Neme (First, Middle, Last) Month Dey **Physician** AUGUST 20, 1998 9:31 PM MARY JEANNE MURPHY /Medical 4b. Cify, Town, or Location of Death 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number) **Examiner** Gilcrest Center Baltimore 5. Sociel Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dev. Year) Birthplece (State or Foreign Country) **Funeral** Deys Min Months Hours 1 M 25 F Yrs. Director 217-18-9494 July 12, 1918 Ohio Usuel Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Kensington Maryland Montgomery 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 9805 Cable Drive Funerai 20895 USA 14. Rece - American Indian. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 11. Maritel Stetus Bleck, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: 1 Never Married 2 Married 1 Yes 2 No Specify: by 3 ₩ Widowed 4 Divorced White Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Neme (First, Middle, Maiden Surneme) 17. Fether's Neme (First, Middle, Last) Be THIRTING Raymond Purce11 Kelly Mary 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Pnint) permit. Pages 1 and 2 Department of Health Important: If Item 27 is any injury or other tree Mary Jeanne Farley (Daughter) 7218 Meadow Wood Way Clarksville, Maryland 21029 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Surial 2 □ Cremetion 3 □ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Gate of Heaven Cemetery 8/24/98 Silver Spring, Maryland 21. Signeture of Funeral Service Licenses 22. Name end Address of Fecility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in deeth) ncvea Examiner Examine physicien end the bunal-transit certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical thet initiated events resulting in deeth) Lest Due to (or es e consequence of): 83 use ed by the detached 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 1 Yes 2 40 3 Probably 4 Unknown signed t þ 24b. Were eutopsy findings eveilable prior to 24a. Wes en eutopsy performed? Completed completion of cause of deeth? page 2 s 1 Yes 1 Yes 2 No 25. Wes case referred to medical examiner? 26. Piece of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 0 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA this funeral 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of Certification: 28c. Injury et Work? 5 Pending Investigation 1 Neturel after death. 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) • Funeral Dire 4 Homicide 5 29e. Certifier 1 Scertifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, and due to the ceuse(s) end menner es steted. To the Hosp within 24 hos To the Fune edical 2 Medical Examiner: On the besis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. (Check only one)

e of deeth (Item 23e) (Type, Print)

32. Registrer's Signature

State Registrar 29b. Signature and

30. Name and address of person who completed

AUG 24

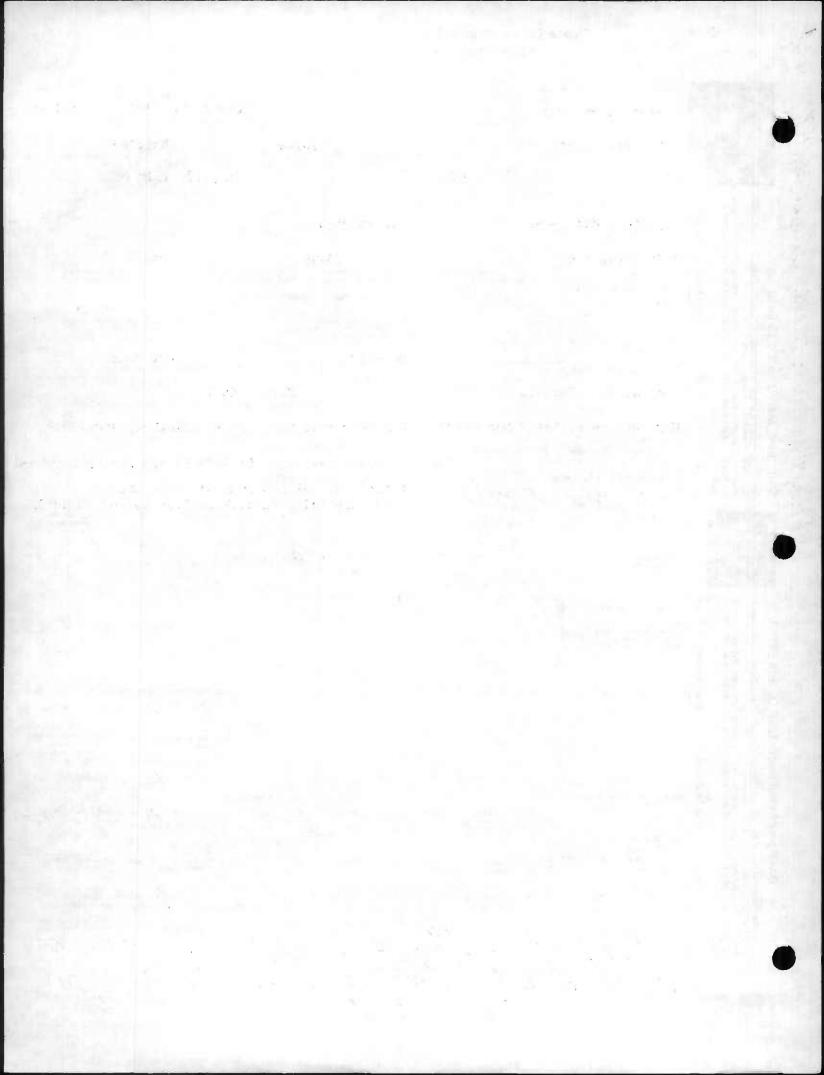
1998

31. Dete filed (Month, Dey, Year)

DHMH 16 Rev 6/95

29d. Date signed (Month, Dey, Year)

N. Chales St. Balto Md



Physicia /Medica Examine

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Madeal Examiner rough or notified at once.

Baltimore, Maryland 21215-0020

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	ame (First, Middle,							2. Date of D Month AUG		ay 199	Yaar	3. Time of Death
		Muthukuma										2000 PM
	e (If not institution, c	give street and num ROAD	ber)					or Location of Dea R SPRING	ith 40		y of Deatl	
Sociel Security 216-17-		3. Sex 1 ☑ M 2 ☐ F	7. Age (In yrs. I. 44	ast birthday Yrs.	Months Months		Jndar 24 H ours Mi		av. Year	54	Co	nplace (Stata or Foreig untry) Lanka
Jsual Rasidance												
Oa. State	10b. County		10c. City	, Town or L	ocation							10d. Inaide City Limits
MD	Montg	omery		Silve:	r Spri	ng						1 ☐ Yes 2 ☑ No
0e. Street and f	Number				10f. Zip	Code			10g. C	itizen of	What Co	untry?
12038 (Claridge	Road				2090)2			Sri	Lank	a
1. Marital Status		12. Wes Deced	dent Evar in U,	S. 13.	. Was Deced	ent of Hispan	ic Origin?	(Specify Yes or Nerto Rican, etc.)		14. Rad	ce - Ame	rican Indian,
1 Never Ma	arried 2 Marrie		2 ₩ No					ento racan, etc.)			ick, White	e, etc.
3 Widowed	d 4 Divorcad	If Yes, Giva Year or Da			1 ☐ Yes 2	No Sp	ecity:			Specif	y: A	sian
	15. Decedent's	Education		16a. Dece	edent's Usua	Occupation		undina.	16b. I	Kind of B	Business/	Industry
	pacify only highast secondary (0-12)	grada completad) Coltege (1-	40r 5a)	(Give	e kind of wor DO NOT us	k done during e retired)	g most of w	vorking				
12		Conege (1-	TOI 3T)	Bus 1	Driver				T	rans	port	ation
7. Father's Nam	ne (First, Middle, La	ast)				18.	Mother's N	lame (First, Middle	e, Maide	n Sumar	me)	
Siriwi	mala Muth	ukumarana	1			I	eela	Wellala	ge			
9a. Informant's	Name/Relationship	p (Type, Print) (V	rife)	19b. Meil	lina Address			Rural Route Num		or Town	. Stete. Z	Zip Code)
Srivania	Mangali	ka Muthuk	umaran:	120	038 C1	aridae	Road	d, Silve	r Sn	ring	MD	20902
Oa. Method of D		na macmar	20b. PI	aca of Disp	osition (Nam	ne of	Road	Date	-			Town, Steta
1 D Burial	2 Cremation 3	Removel from S	tata	emetery, cre	ematory or ot	her place)					,	
4 Donatio	- F Ohner /Con				_							
	n 5 Other (Spe		Met	tropol	litan	Cremat	ory	8/30/98	Ale	xand	lria,	VA
	Funeral Service Lie		Met	1	22. Nama and Home,	Cremat Addrass of Inc.	Facility 500 I	Francis . Universi	J. C	olli	ns F	uneral
21. Signature of	Funeral Service Lie	trud complications that ca	used the deeth	2	22. Nama and Home, Silver	Cremat Addrass of Inc. Sprin	Facility 500 I	Francis . Universi D 20901	ty B	olli	ns F	uneral t Approximate
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To the Funeral Director: After this cartificate has been signed by the attending physician and completaly filled in by the funeral director, paga 2 should be datached for use as the buriel-transit The law requires that the death certificata be executed Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law within 24 hours after deeth.

To the Funeral Director: After this cartificate has it

Physician /Medical **Examiner**

Medical Certificati

2 ☐ Accident 3 ☐ Suicide

4 Homlcide

29a. Certifier (Check only one)

6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

111 Penn Street, Baltimore, Maryland 21201

28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 12038 CLARIDGE RD HONTGOLGHYCO

1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, dete end piece, end due to the cause(s) and menner es steted.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the ceuse(s) and manner stated.

29b. Signature and title of certified

AUG 27 1998

29c. Licensa number O.C.M.E 29d. Date signed (Month, Day, Year) AUG. 24, 1998

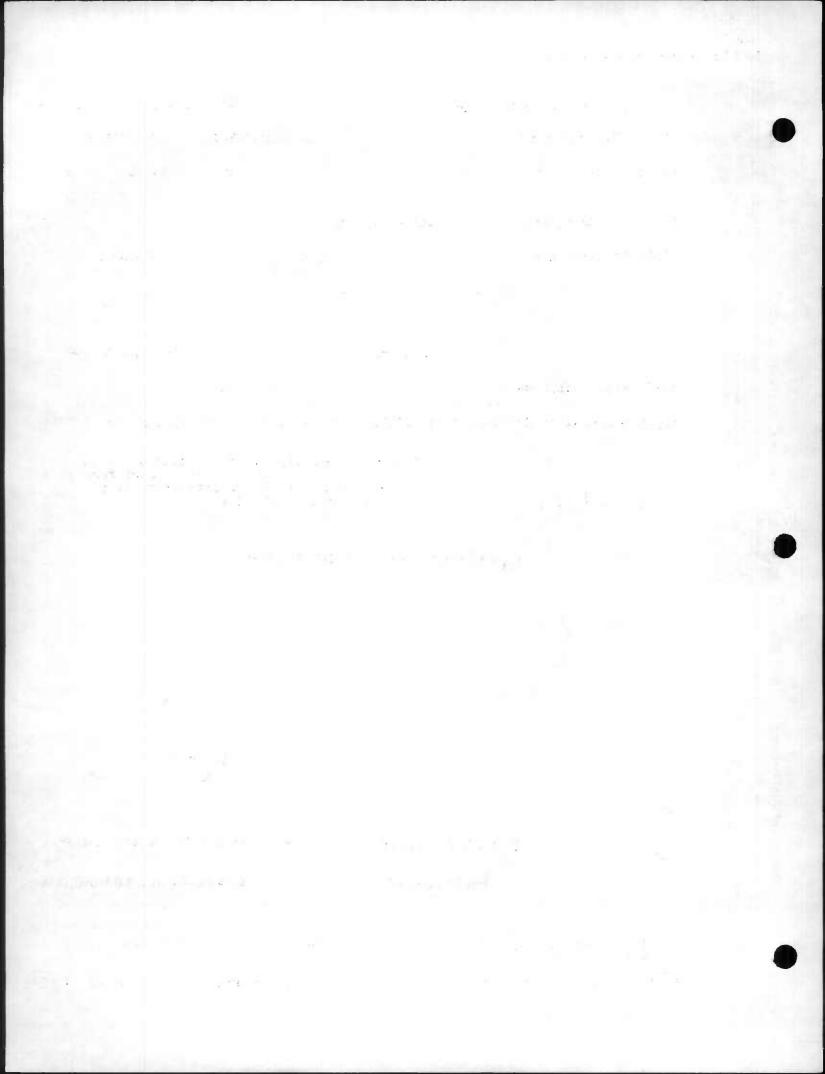
30. Neme and eddress of person who completed cause of death (item 23a) (Type, Print)

HARYDNION 31. Date filed (Month, Day, Year)

32. Registrar's Signature

State Registrar

3



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Physician	1	I. Decedant's Nar		la, Last)	M 1	1		rtificate	oi Dea	2(11	2. Data of Da Month AUGUST	Reg. No. ath 1 23, 19	Year 98	3. Tima of Death 7:11 PM
/Medical Examiner		a Facility Nama	(If not institution				ana		4b. Ci		ocation of Daeth	4c. County	of Death	
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th with the Mar 23a or 28a-f s and be neutral	1	0e. Street end No.	umber					10f. Zip Co	da 902			10g. Citizan of N		ntry?
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Evaniner man be notified at To Be Completed by Funeral Director	1	11. Marital Status 1 2 Nevar Mer 3 D Widowad	riad 2□ Mai	12. Was	s Decedant ad Forces? Yas 2 🔀 es, Give ir or Dates:			Was Dacedan If Yas, specify 1 ☐ Yas 2 ☑		lc Origin? (Sp xxlcan, Puerto ecify:	pecify Yas or No Ricen, atc.)	Specify	ck, Whita,	cen Indien, atc. ian
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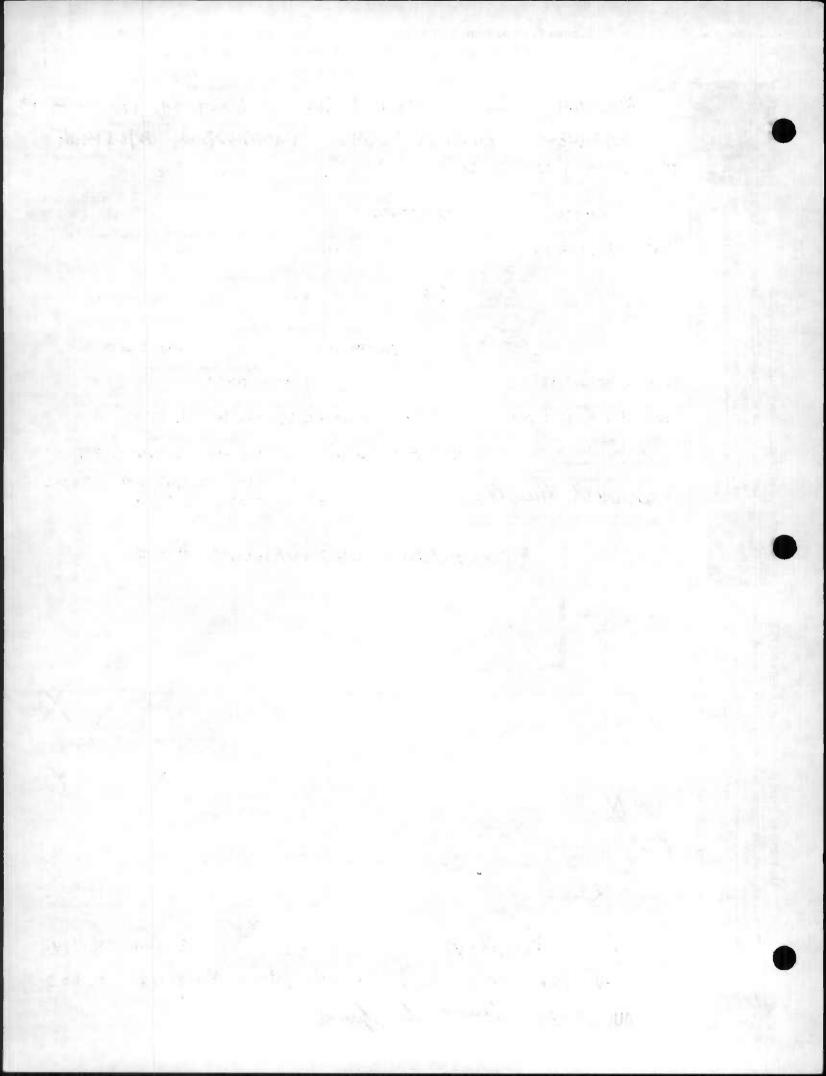
State Registrar

AUG 2 7 1998

32. Registrar's Signatura B. Sparks

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					Cei	rtificat	e of L				Reg. No.	98	hour I	10 10 1
Physici /Medi		1. Decedent's Name (First, Middle, La BER NAM)	C.		MC	Dou	c At	ı		2. Dete of D Month AUGUS	eath Day	Yea	r	3. Time of Death
Examir	_	4a Facility Name (If not institution, given NORTHWES	or HI	OSPITA		C GVI	FR	b. City, To	TND	cation of Dea	un	PAT L	TU	
Funeral Director			Sex ↑CXM 2□ F	Age (In yrs. las 73	Yrs.	Months	Deys	Hours	Min.	8. Date of Bi (Month, D June 2	2 192	5 M	Country,	a (State or Foreign
iter death with the Maryland items 23s or 28s-f show the must be notified at	ctor	10a. State 10b. County Md Carroll			Town or Lo								10d.	Inside City Limits 1 ☐ Yes 2 No
th with th	al Dire	10e. Street and Number 7626 College Ro	ad			10f. Zlp	217	84			10g. Citize	en of What	Country	7
n 72 hours effer death with the Maryland "netural", or Herra 23s or 28s-f show oddell Examinet must be notified at	by Funeral Director	11 Maritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Deceder Armed Force 1 Tyres 2 E If Yes, Give Year or Detes	s? □No 19	44-	Was Deced If Yes, spec 1 ☐ Yes		ispanic Ori n, Mexican Specify:		ecify Yes or N Rican, etc.)		Black, W	hite, etc	
d within giene. r than	Completed	15. Decedent's E (Specify only highest gri Elementery/Secondary (0-12)	ducation ade completed) Cotlege (1-40 +6	or 5+)	(Give	dent's Usua kind of wo DO NOT us harma	rk done d se retired	du <i>ring</i> most ()	t of work	ing		th ca		try
should be filed and Mental Hygie is marked other turnatic event, the	To Be C	17. Father's Name (First, Middle, Last Charles McDougal								enecki	e, Meiden S	umeme)		
d 2 shoth end the end T is me traum		19a. Informant's Name/Retationship (Mark McDougall								ai Route Num. Ville,			e, Zip Co	ode)
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permit. Pag Department Important: I any Injury o		21. Signature of Funeral Servica Lica	Here It's	-21		2. Name an			na.	ight Fu			& 0	Chapel
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		1 December Norse (First Middle A		arylarid /	Certificate of		F	leg. No.		7442
Phys	ician	1. Decedent's Name (First, Middle, L	ast)				2. Date of Dee Month	Dev	Yeer	3. Time of Deeth
	dical	Wanda Gail Moore 4e. Fecility Name (If not institution, g	ive street and number)			4b. City, Town, or Lo		-	1998	1805
Exan	niner	338 East Village				Elkton	cation of Deeth	4c. County Ceci		
Funer Directo	_	5. Sociel Security Number 6. 217-64-1441		e (In yrs. lest bi	rthdey) If Under 1 Yaar Yrs. Months Deys	If Under 24 Hrs. Hours Min.	8. Date of Birti (Month, De) tember	, Year)	9. Birthplac	e (Stete or Foreign ama
pue *		Usual Residence of Decedent 10a. Stete 10b. County		10c. City, Tov	n or Location					Inside City Limits
n the Maryland r 28a-f show	5								100.	1 ☐ Yas 2 ☑ No
r 28a	Director	Maryland Cecil 10e. Street and Number		North	East 10f. Zip Code		1	I0g. Citizen of V	Vhet Country	?
th wit		109 East Huron C	ourt		2190	1	- 1	United	States	
15-0020 n 72 hours efter death with the Maryland "natural", or Items 23s or 28s-f show edical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Marriad 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 1 N If Yes, Give Yeer or Detas:		13. Was Decedent of H If Yes, specify Cube 1 ☐ Yes 2 ☑ No	dispenic Origin? (Spean, Mexican, Puerto Specify:		14. Rac	e - American k, White, etc.	Indian,
Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours eft Depertment of Health and Mental hygiene. Important: If Item 27 is marked other than "natural", or any injury or other traumetic event, the Medical Examination of the contract of the medical Examination of the contract of the Medical Examination of the contract of the Medical Examination of the contract of the Medical Examination of the contract of the con	Completed	15. Decedent's E (Specify only highest g Elementary/Secondery (0-12)	Education rade completed) College (1-4or 5	+)	Decedent's Usuel Occup (Give kind of work done life. DO NOT use retired	durina most of worki	ing	16b. Kind of Bu	siness/Indus	try
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2 sho and I s me				198	o. Meiling Address (Street	end Number or Rure	al Route Numbe	r, City or Town,	Stete, Zip Co	de)
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Baltimore, Demit. Pages 1 au Depertment of Hea mportant: If Item any injury or othe	19a. Informent's Neme/Relationship (7 Virginia A. Buong Sister 20a. Method of Disposition 1		ify)	Cherry	ry, cremetory or other plea Y Hill Metho	dist A	ugust 28 1998			Stete Maryland
Ball Seperal Mean in the line	DUCE	21. Signature of Funeral Servica Lice	ensee	_	22. Name end Addre Hicks Home	ss of Fecility for Fune:		.A.		
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Physician /Medica Examine	l r	Immediete Ceuse (Final diseese or condition resulting in death)	e. Men	Due to (or es e	consequence of):				Or	nset end Deeth
68 / 60, ificate be executed g physician and as the bunal-transit	al Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events	c		consequence of):					
Certification of the second of	Physician/Medical	resulting in deeth) Lest	d	Due to (or es a	consequence of):					
the death by the etter ached for u	/slc	Pert II. Other eignificent conditione	contributing to death bu	t not resulting i	n the underlying cause giv	en in Pert I.	23b. Did to	obacco use cor	ntribute to the	cause of death?
T to the	by Ph						1 🗆 Y	es 2 No	3 Probab	ly 4 □ Unknown
VICAL RECOIDS, P. sician: The law requires that certificate hes been signed be irector, page 2 should be deta	Completed						24e. Wes a perfor		availe	eutopsy findings ble prior to etion of cause th?
T VITAL MO ysician: The is is certificete he director, page							1 🗆 Y	as 2 No	1 🗆 Y	es 2 No
VIII lician certifi recto	Be	25. Was case referred to medical exeminer?	Hospitel:		utantinat 20 DOA Oth	26. Piece of Death	-	7		
VISION OF VITA Attending Physician: or death. bector: After this certific by the funeral director,	ion: To	1 Yes 2 No 27. Menner of Deeth Naturel 5 Pending 2 Accident investigation	28e. Dete of Injury (Month, Dey	y. 28b.	Time of 28c. Injury	4 □ Nursing Hor	me 5 Residence 128d. Describe h			
	Certification:	2 Accident investigation 3 Suicide 6 Could not lead to determined	De Diago of Inju	ry - At home, fa . (Specify)	arm, street, fectory, office		28f. Location (S City or Town	treet end Numb n, Stete)	er or Rural Ro	oute Number,
To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	edical	29a. Certifier (Check only one) Certifying P	hyelclan: To the bast of miner: On the basis of and manner stel	examinetion en	e, death occurred at the tin d/or Investigation, in my o	na, data and plece, e pinion, deeth occurre	end due to the co	ause(s) end me ate end plece, a	nner as state and dua to the	d. e ceuse(s)
To the To the Comp	X	29b. Signeture and title of confiler	1		29c. Licans	a number	2	9d. Date signed	(Month, Dey	, Year)
1		VXE.	h		D 32	395		8-25-98		
		30. Name end eddress of person who				1 (Thomas	s E. Fi	nucan M	D.	
S Regis	tate trar	31. Dete filed (Month, Day, Year) AUG 2 8 1998		r's Signature	frank !				- · ·	

10c. City, Town or Location

North East

10f. Zip Code

Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Day Month Mary McClanahan 26, AUGUST 1998 12:31 PM 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 8. Dala of Birth (Month, Day, Year) Days 1 □ M 2 1 F 227-42-9297 68 December 7, 1929 Virginia Usual Rasidanca of Dacedant

21901

1 Yes 2 No Specify:

16a. Decedent's Usual Occupation (Gave kind of work done during most of working life. DO NOT use retired)

Assembly Line Worker

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.)

10d. Inside City Limits

10g. Citizen of What Country?

United States

14. Raca - American Indian,
Black, Whita, etc.

Specify: White

Manufacturer

29d. Data signed (Month, Day, Year)

August, 26, 1998

16b. Kind of Business/Industry

Fireworks

18. Mother's Name (First, Middle, Maiden Surname)

Ollie Myrtle Sayers

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 103 Superior Court, North East, MD 21901

1 ☐ Yes 2 ☑ No

Funeral Director

Physician

/Medical

Examiner

28a-1 show ò Наста 23а than "natural", or han filed within 7 Hygiene. Wher then "n permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy important. If then 27 is marked other any injury or other traumatic event.

> physician and the burial-transit peed this After t

Baltimore, Maryland 21215-0020 **Physician** /Medical Examiner Box 68760. the death certificate be Records. P.O. Division of Vital Hospital or Attanding after death.

Director: Aft
d in by the fur 24 hours after e Funeral Direc Medical within 2

10a Stata Director Maryland 10e. Street and Number 103 Superior Court Funeral 11 Marital Status 1 ☐ Nevar Married 2 ☑ Married à 3 ☐ Widowed 4 ☐ Divorced Completed 4 Be 10 Examiner Physician/Medical by Completed Be To 27 Mannar of Death Certification: 1 DN Neturel 2 Accident 3 ☐ Suicide 4 Homicida

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 17. Fether's Neme (First, Middle, Last) Ezar Marshall 19a. informant's Name/Relationship (Type, Print) Charlie Leo McClanahan / Spouse 20e. Mathod of Disposition immediate Ceuse (Finel disaasa or condition rasulting in death) Sequantially list conditions, if any, laading to immadiata cause. Enter Undarfying Cause (Disaasa or Injury that initiated avants rasulting in death) Last

29b. Signature and title of certifier

31. Dele filed (Month, Day, Year) AUG 2 8 1998

Fan

10b County

Ceci1

12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yes, Give Year or Dates:

College (1-4or 5+)

20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location - City or Town, Stela Data Aug. 29 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specity)

21. Signature of Funeral Service Licenses North East Methodist Cem. 1998 North East, Maryland 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, MD 21901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one cause on each line. Approximete Intarval Between Onset and Death Sepsis days Hepatic Failure Fulminant days Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert 1. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? 1 Yes 2 □ No 1 ☐ Yes 2 No 25. Was casa rafarrad to medical axaminar? 26. Placa of Death (Check only one) Hospital: 1- Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No 28a. Data of injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and placa, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at tha time, data and placa, and due to the cause(s) and manner stated. 29e. Certifier (Check only one)

State Registrar

DHMH 16 Rev 6/95

8

medical resident

/32. Registrar's Signature

600 N Wolfe

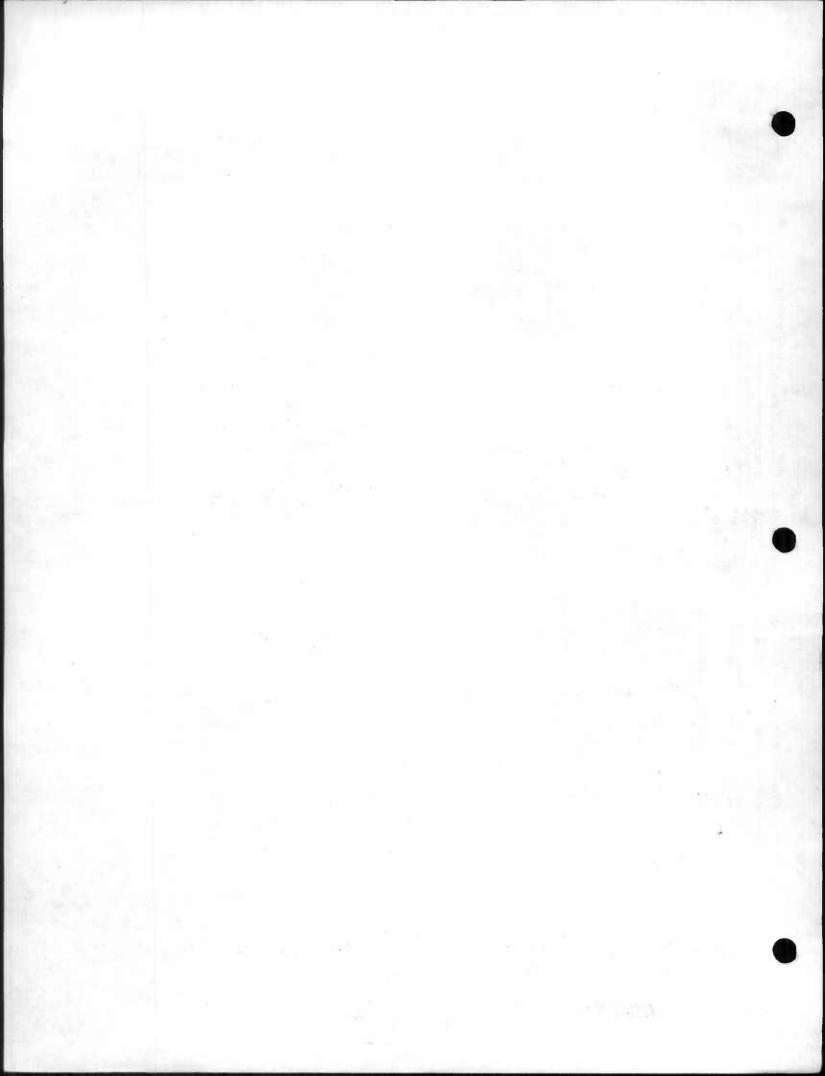
30. Nema end addrass of person who completed causa of death (Item 23a) (Type, Print)

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29c. License number

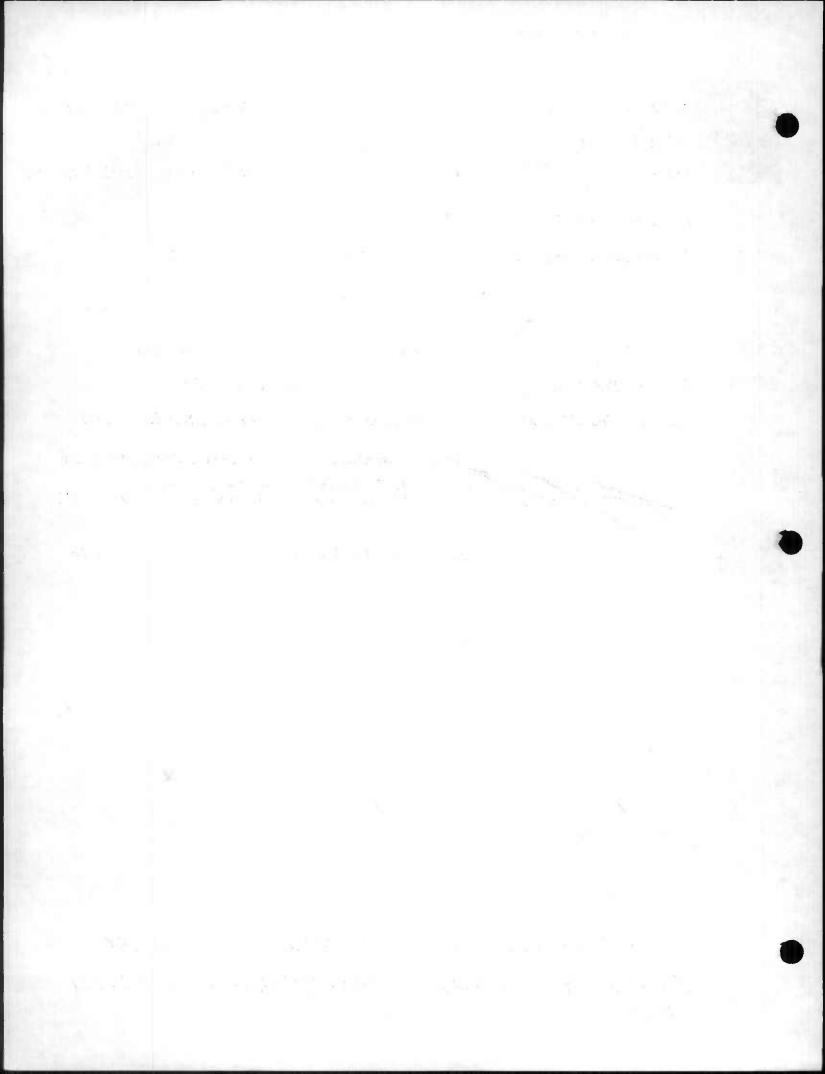
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Street Baltimore MO 21287



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Physicia	an I	1. Decedent's Neme (First, Mi				201	rtificate of		2. Dete of De	Reg. No.	Yeer	3. Time of	i Deeth
/Medica	ai	J. Eugene McM. 4a. Facility Name (If not institu		tract and number	m)			4h Cihr Tourn o	August	26	1998	9:38	s AM
Examine	er	Union Hospital		raer and number	()			Elkton	Location of Deet	Ceci	y of Deeth		
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or 28	Director	10e. Street end Number					10f. Zip Code			10g. Citizen of	Whet Count	ry?	
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of ber	Physician/M	Part II. Other significent cond	itions cont	rlbuting to death	but not res	ulting in tha ur	nderlying ceuse g	iven In Part I.	23b. Dld	tobacco use co	ontribute to	the cause o	of dea
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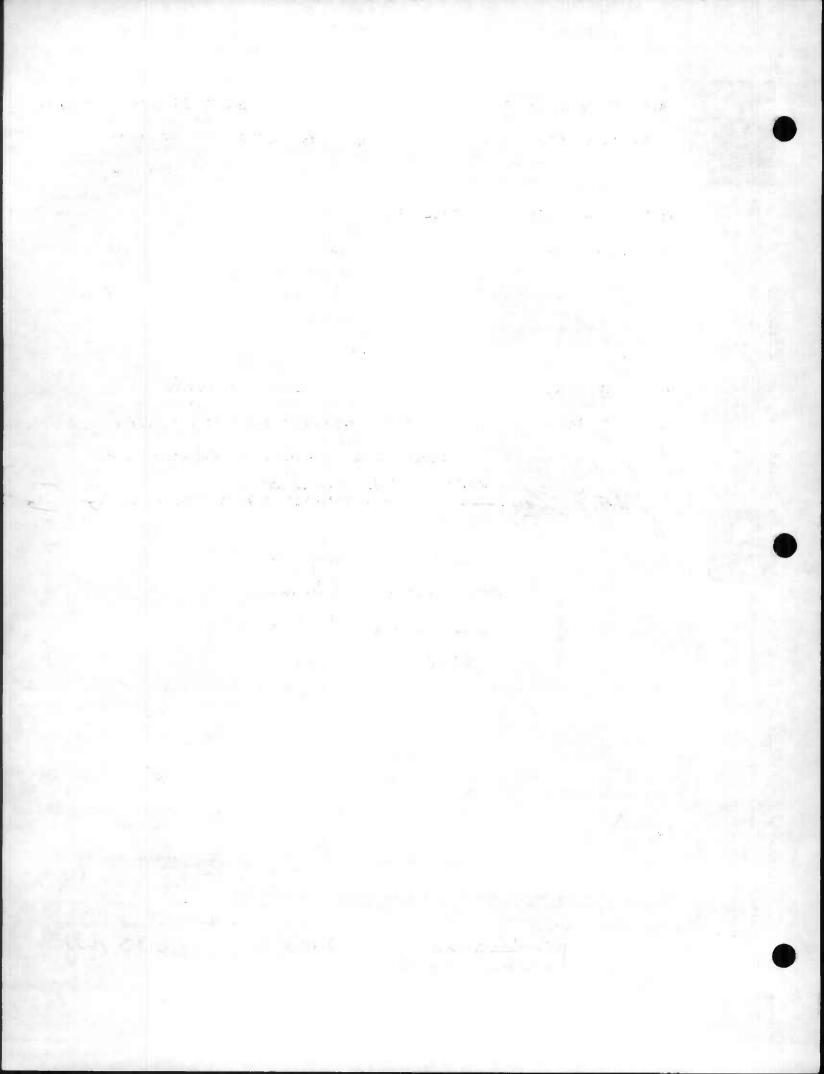


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To the Hospital or Attending Physician 24 hours effer death. To the Funeral Director: After this completely filled in by the funeral Medical Certification:	29e. Cartifiar (Check only one)	tifying Phys lical Exami	alcian: To the be ner: On the basi and manna	s of axamina	owledge, dea ation and/or i	th occurred	d at tha	tima, deta er opinion, dar	nd place, a	and dua to tha ed at the time,	cause(s) end modele and placa,	enner as s and dua t	tated. o tha causa(s)
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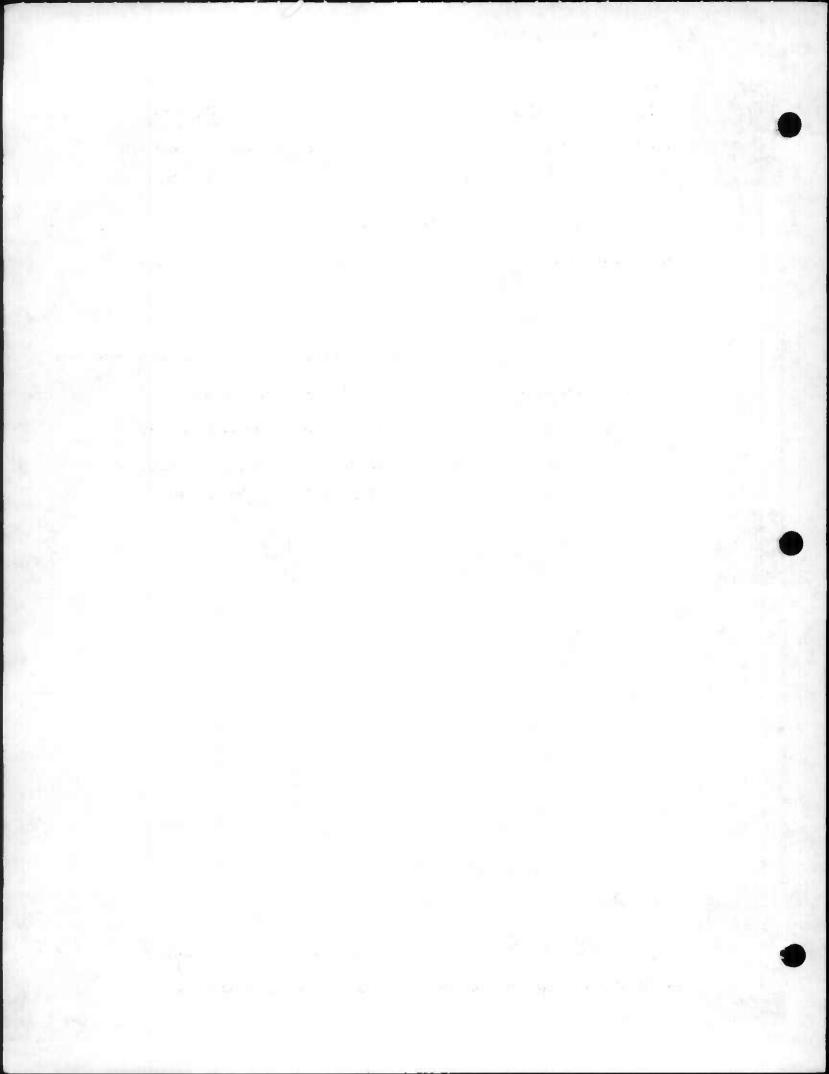
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Dhusis	lon	Decedent's Name (First)	, wilddie, Las	SI)						2. Date of		V		of Death
Physic /Medi		William A	A. Nor	ris Jr.						Aug 1	.9, 199	Year		0 p.
Exami		4a. Facility Name (If not in	stitution, give	street end numb	oer)				4b. Cify, Town, o	or Location of De	_	ounty of Dea	ath	.ор.
		10715 Hink	le Ro	ad					Cumboul	and	7.7.7			
uneral		5. Social Security Number	6. Se	ex 7.	Age (In yrs	. lest birthdey)		er 1 Year	Cumberl Under 24 H	rs. 8. Date of I	Birth	Legany 9. Bi	rthplace (Stet	or Fore
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how		10a. State 10b. 0	County		10c. C	ity, Town or Lo	ocation						10d. Inside	City Lin
a-f-a	Funeral Director	MD All	Legany			Cumber	rland						1 🗆 Y	es and
or 28	Oire	10e. Street and Number			-		10f. Z	ip Code			10g. Citize	n of What C	Country?	
238	a	10715 Hinkl	e Road	i				21502			1	USA		
E	nei	11. Marital Status		12. Was Decede	ent Ever in U	J,S. 13.				(Specify Yes or I erto Rican, etc.)		. Race - Am	erican Indian,	
than "natural" or frems 23a or 28a-f ahow the Medical Examiner must be notified at	by Fu	1 ☐ Never Married 3 ☐ Widowed 4 ☐ Dir		1 Yes 3/ If Yes, Give Yeer or Date	□ No		1 ☐ Yes		Specify:	atto moan, atc.)		Black, Whi		
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om 27 is other treu		Sue L. Norr	is-wif	fe						mberland				
= -		20a. Method of Disposition				Place of Dispo	osition (Na	ime of		Date			r Town, Stete	
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Honth Hug. 450 **WATLITY** ALFRED NIBLETT 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, giva street and number) 4c. County of Death SALISBURY If Under 24 Hrs. 8, [Hours Min. (6) PENINSULA REGIONAL MEDICAL CENTER WICOMICO If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) Days 1 M 2□ F Yrs August 11, 1925 220-16-7569 Maryland Usuat Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland Wicomico Delmar 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 700 E. Chestnut St. 21875 USA 12. Was Decedent Evar in U.S. Armed Forcas? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 Yas 2 No f Yes, Giva Army Army Yaer or Dates: Air Corp 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 ₺ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Cotlege (1-4or 5+) Office Equipment Sales 17, Fether's Nama (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) William Alfred Niblett Mamie Davis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Gail Lowe/Daughter 700 E. Chestnut St., Delmar, MD 21875 20b. Ptece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removat from State 8/19/98 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 21. Signature of Funeral Service/Licease 22. Name end Address of Facility Holloway Funeral Home 23a. Part1. Enter the disease, or complications/that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. A 23a Part1. Enter the disease, or complications/that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. A 25a Part1. Enter the disease, or complications/that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. A 25a Part1. Enter the disease, or complications/that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. CESP Approximete Intervat Between Onset and Death Immediate Cause (Final disease or condition resulting in deeth) pracie Scotic Aprel Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 18 Yes 2□ No drawal 25. Was case referred to medical 26. Place of Seath (Check only one) Hospital: Other: 4 Nursing Home 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work?

Physician /Medical Examiner

Department of Health end Important: If Item 27 is m any injury or other traum once.

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or itema 23a or 28a-f show the Madical Examiner must be notified at

Hygiene

Pages 1 and 2 should be end Mental

land

Mary

Baltimore.

Box 68760

P.O.

Records,

Division of Vital

Director

Funeral

þ

Completed

Be

Examine physicien and the burief-transit Physician/Medical

þ Be Completed Aftar this death.

Hospital or Attending Director: sfter To the Hospital o within 24 hours aff To the Funerel Di completely filled in

Medical Certification: To 29b. Signature end title of certifier 31. Date filed (Month, Day, Year)

Registrar

AUG 1 9 1998

1 Maturat

2 Accident

3 ☐ Suicide

29a. Certifier (Check only one)

4 Homicide

who completed cause of death (Item 23a) (Type, Print) Eva

5 Pending investigation

6 Could not be

ista

32. Registrar's Signeture

28e. Ptaca of Injury - At home, farm, street, fectory, office building, etc. (Specify)

29c. License number

1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 Yes 2 No

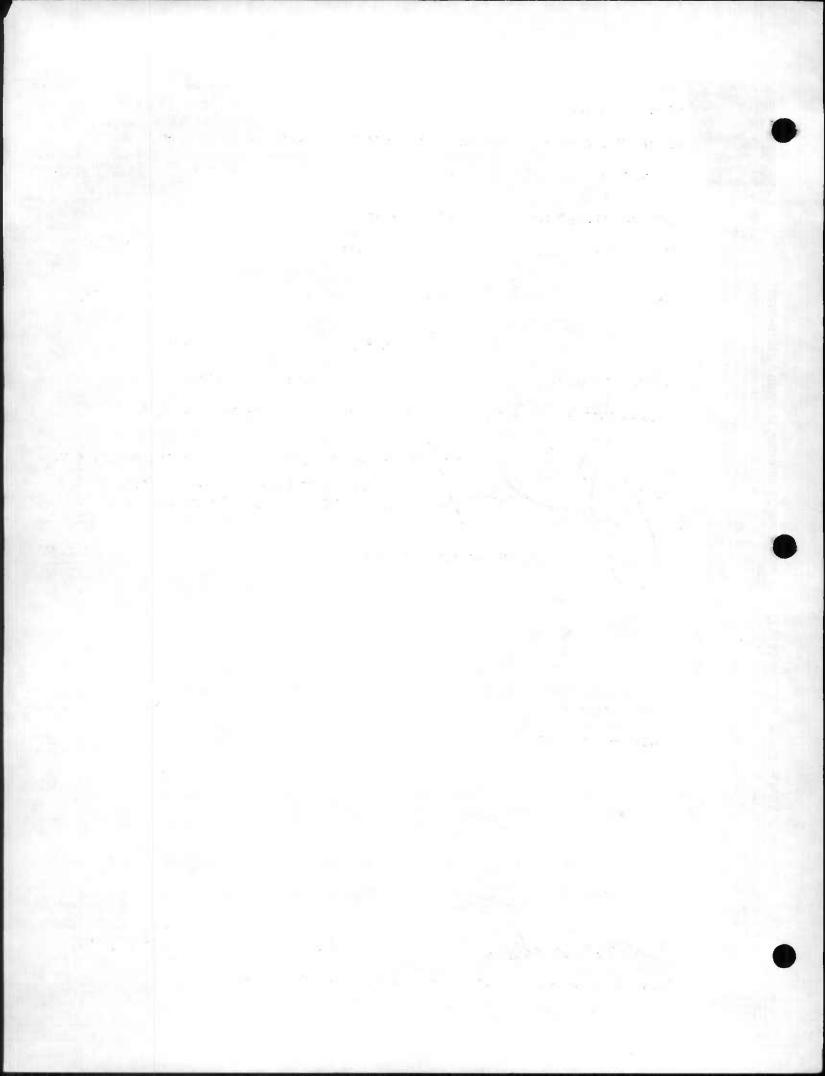
29d. Date signed (Month, Day, Year)

281. Location (Street end Number or Rural Route Number, City or Town, Stete)

19 h Live of the Park o

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

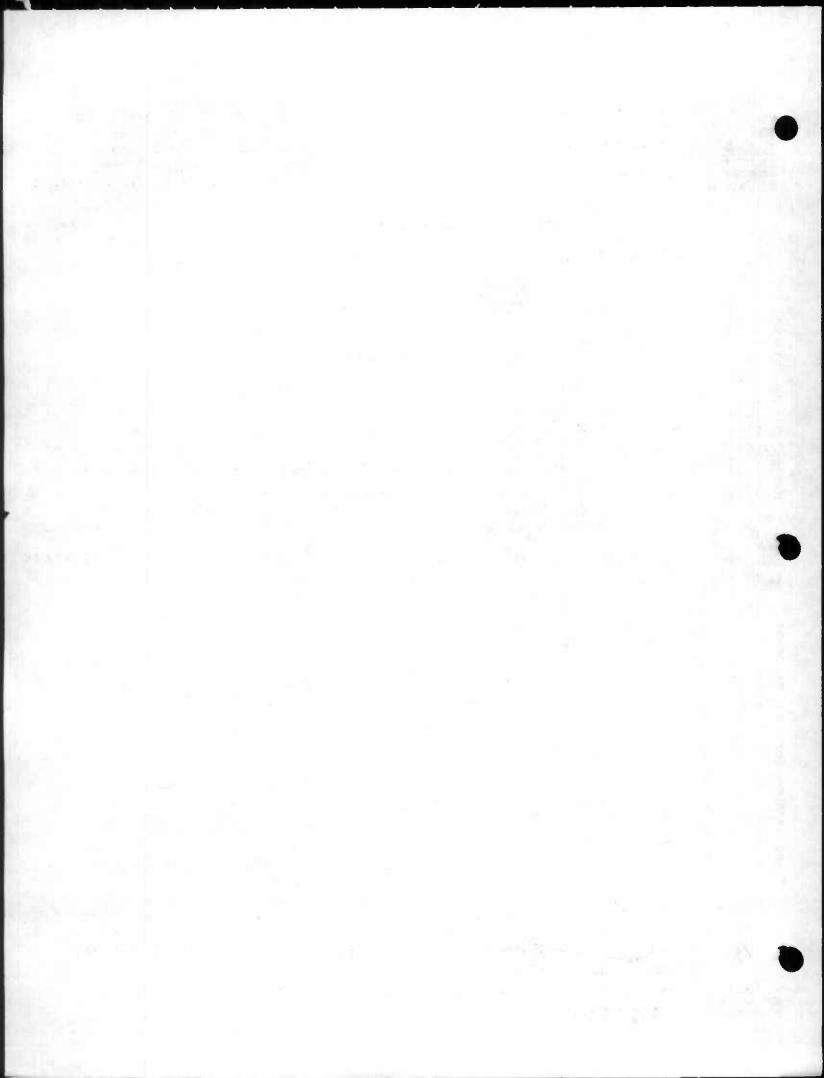
	State of M	, , , , ,				Death			Reg. No.	8 2	74	+8
1. Decedant's Name (First, Middla, Las	st)	Philip						2. Data of Dee	Day	Yaer		of Death
DAVID NEUHAUS 4a Fecility Nama (If not Institution, give	a street and sumbar	·)				th City Tow		UGUST ation of Death		998	3:3	0 am
MARINER HLTH. NURS			LVER	SPRI		SILVE				GOMERY	7	
5. Social Security Number 6. S.		ga (In yrs. la	st birthday,		er 1 Yaar	If Under 2	4 Hrs.	B. Data of Birti (Month, Day I-18-I	h /, Year)	9. Birthpl	aca (State	or Foreign
067-09-7183 Usual Rasidance of Decedant	QM 201	87	Yrs.					1-18-1	.1	NEW Y	ORK	CITY
10a. Stete 10b. County			Town or L							10		City Limits
MARYLAND MONTGOME	ERY	SIL	VER S	-					10 000 11			s 2 No
10e. Street and Number 11714 KEMP MILL RD).				ip Coda 902				10g. Citizen of UNITED	STATE	ES	
11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedan Armed Forcas 1 1 Yas 2 If Yas, Giva Yaar or Datas:	? I No		Wes Dec If Yas, sp		lispanic Origi en, Maxican, Specify:	in? (Spec Puarto R	ify Yes or No- ican, atc.)	Ble	ca - Amarica ck, Whita, a by: WHIT	atc.	
15. Decedent's Ed (Specify only highest gra	lucation de completed)		16a. Dace (Give	dant's Us	uel Occup	ation during most o	of working	9	16b. Kind of B	usinass/Ind	lustry	
Elementary/Secondary (0-12)	College (1-4or	5+)		UNTA		d)			ACCOUNT	TING		
17. Father's Name (First, Middle, Last) IRVING NEUHAUSE								First, Middle, EFELGE	Maidan Sumer IST	me)		
19s. Informant's Name/Relationship (18 BARBARA WIEDER	Type, Print) DAUGHTER		190 Main 1171	ing Addre	ss (Street	and Number	or Rural	Route Numbe	RING 2	0902 ^{zip}	Coda)	
20a. Method of Disposition		20b. Pta	a of Disp	osition (N	ame of			Data	20c. Location	- City or To	wn, Stata	
1 ☐ Burial 2 ☐ Cremation 3 € ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	8: 1	matary, cra M∩NTF			ca) (ETERY	8-	23-98	FARMIN			
21. Signature of Funeral Service Licen		1	2	2 Namas	and Addra	ss of Facility	-		AL CHAP	FI T	NC.	
XX 1		+							VILLE,			
23a. Part 1/ Enta the diseasa, or comp	plicetions that cause one cause on each	ed the deeth.	Do not en	tar tha mo	da of dyir	ng, such as c	ardiac or	raspiratory ar	rast,		Approxim Intarvel B	etwaen
		1)									Onset an	
Immediate Cause (Rinal disease or condition resulting in death)	a ASPIR	ATION	PNEUN	MONIA							2 WE	EKS
		Dua to (or	as e conse	quanca of):							
Sequentially list conditions.	b	Dua to (or a	as a consa	quanca of):					-		
Sequantially list conditions, if any, leading to immediate causa. Entar Underlying Causa (Disease or Injury												
that initiated avants rasulting in death) Lest	0	Dua to (or a	is a consa	quance of):					1		
	d									1		
Part II. Other significant conditions co	ontributing to death	but not rasult	ing in tha	undarlying	causa giv	an in Pert I.		23b. Dld 1	lobacco uae co	ontributa to	the caus	of death?
SEVERE DEMENTIA								10	Yes 2 No	3 Prot	pably 4	Unknown
DECUBITUS ULCER	S							24e. Wes	en autopsy	24b. Wa	ara eutops	y findings
DECUBITUS ULCER	.5							perfo	rmed?	00/	alleble price mpletion of daath?	
								101	as 2XXNo	10	Yes 2	□ No
25. Was case raferred to medical axaminar?	Hospital:				Oth			(Chack only o				
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1 ♣ Natural 5 Pending 2 Accidant invastigation		ay Year)	fnjury	М		rk? Yes 2□N	lo					
3 Suicida 6 Could not be 4 Homicide determined	288. Placa of II	njury - At hom etc. (Specify)	na, farm, si	traat, facto	ory, offica		21	Bf. Location (S City or Tov	Straet and Num vn, Stete)	ber or Rura	I Routa N	ımber,
	ysician: To the besi niner: On the basis and manners	of examination										ı(s)
295. Signature and title of certifier	and manner s	nateo.		2	9c. Licans	a number			29d. Date sign	ed (Month,	Day, Year)
> SAIROJO	elener			D	09834				AUGUST	23, 1	1998	
30. Nama and addrass of person who				, Print)				20000				
BARRY N. ROSENBA	AUM 3720	FARRA	GUT A	VE.	KENS	INGTO	N, MI	20895				
31. Dete filed (Month, Day, Year)	32. Regis	trar's Signatu	ITA .	1	pork	1						



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State of Maryland / Department of Health and Mental Hygiene 27 12 12 9

		1. Decedant's Nama (First, Midd	lla, Last)						2. Data of Das			3. Tima of Dea
Physician /Medical		Virginia Grace O'BRIEN							August	15 19	998	7:00 P.
xamine		4a. Facility Nama (If not institution		ımber)				4b. City, Town, or Location of Da				
		723 Arundel St.					Cumbe					
neral ector		5. Social Sacurity Number 235–20–0289	6. Sax 1 ☐ M 2 ☐ F	M 2XF 76 Yrs. Months Da				Min.	8. Data of Birth (Month, Day NOV • 1	ta of Birth 9. Birthplaca (Sta Country) V. 11,1921 West Virg		olaca (Stata or For otry) Virginia
_		Usual Rasidance of Decadant 10a. Stata 10b, County	/	10c. (City. Town or	Town or Location					1.	10d. insida City Lir
notified at	0	MD Alle	gany	Cumberland								1 □ Yas 2 □
tout	2	10e. Straat and Number		10f. Zip			oda		1	10g. Citizan of What Country?		ntry?
dian	<u>a</u>	723 Arundel St	•	2150			2			U.S.A.		
Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Navar Marriad 2 □ Mar 3 ☑ Widowad 4 □ Divorced	Armed Formation 1 Tas If Yas, Given	12. Was Dacadant Evar in U,S. Armed Forcas? 1 Yas 2 No If Yas, Giva Y Yaar or Datas: ducation ada complatad) Collage (1-4or 5+)		J.S. 13. Was Dacedant of Hispanic Origin If Yas, specify Cuban, Maxican, It I		pation		14. Race - Amaricen Indian Black, White, atc. Specify: White 16b. Kind of Businass/Industry		atc.
A les	0	15. Dacedar	nt's Education									
other traumatic event, the Medical Exervi	Completed	(Spacify only higha Elamentary/Secondary (0-12)	collage (Own Home		
Re C		17. Fathar's Nama (First, Middla,								Maidan Sumama)		
To		Oscar L. Hovatt	cer				Myr	Myrtle Collins				
9		John J. O'Brie							ural Routa Number, City or Town, Stata, Zip Coda)			
any injury or other to	-	20a. Mathod of Disposition	en / Son	20h		Arundel		umber	land,			Chair
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any ir									Home, P.A.			
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedant's Nama (First, Middle, Last) Month Day **Physician OSBORNE** LILLIE 3:50 am MAY August 9,1998 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Memorial Hospital & Medical Center Cumber land **Allegany** 5. Social Security Number If Under 1 Year 8. Sax 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1□M 2Ñ F Months Hours Yrs. 214-28-7136 Director 68 6/4/31 PA Usual Rasidance of Decedent the Marylend 10e State 10b. County 10c. City. Town or Location 10d. tnslda City Llmits 28a-f show 7 is marked other than "natural", or itama 23a or 28a-f ahov traumatic event, the Magical Examiner must be notified at 1 ☐ Yes 2 ☑ No PA Somerset Southampton Township Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 145 Kennells Mills Road 15545 USA Funeral 72 hours efter deeth 14. Raca - American Indian. 12. Was Decedant Evar in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Navar Married 2 Married 1 Yes ZONo Baltimore, Maryland 21215-0020 Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade complated) 16b. Kind of Business/Industry filed within 7 Hygiena. Elamantary/Secondary (0-12) Collega (1-4or 5+) 8 Wiring Technician Manufacturing 18. Mother's Nama (First, Middle, Maiden Sumame, 17. Fathar's Name (First, Middla, Last) permit. Pages 1 end 2 should be f Department of Health end Mental I Important: If Item 27 is marked of any injury or other traumatic eve Clarence Benjamin Emerick Soloma Clites Emerick 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type, Print) William G. Osborne, spouse 145 Kennells Mills Road, Hyndman, PA 15545 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1

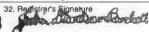
Burial 2 □ Cremation 3 □ Removal from State
1 □ Donation 5 □ Other (Specify) Comps Cemetery 8/12/98 Southampton Twp, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility any in Harvey H. Zeigler Funeral Home Hyndman , PA 15545

23a. Pert1. Enter the disease, ir complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heert failure. Lil tonly one cause on each trial. Approximate Interval Between Onsat and Death Physician /Medical Immediate Cause (Final disease or condition rasulting in death) FEBRUARY 98 a ADVANCED METASTATIC INFLAMMATORY BREAST CARCINOMA Examiner Dua to (or as a consaquance of): Examiner FOUR WEEKS MALIGNANT PLEURAL EFFUSION physician end s the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last Due to (or es a consaguenca of): Box 68760 Physician/Medical Due to (or as a consequence of): ettanding **BSD** 23b. Did tobacco usa contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 0 the signed by t 1 Yes 2 No 3 Probably 4 Unknown م Records, by 24b. Were autopsy findings available prior to Completed 24e. Was an autopsy peen s completion of causa of dasth? has page 2 1 ☐ Yas 2 H No 1 Yes 2 No cartificete Division of Vital or Attending Physician: funeral director, 25. Was cesa raferred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 Yes 25€No 1 Npatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of Certification: 28a. Data of Injury (Month, Day Year) 28c. tnjury at Work? After 1 Natural 5 Pending 1 ☐ Yas 2 ☐ No invastigation deeth. 2 Accident after deetl Director: 6 Could not be 3 ☐ Suicide Location (Straet and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) á 4 - Homicida 24 hours aft Funeral Di edical 29a. Certifier 1 😭 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and dua to the cause(s) and manner as statad (Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Within 2 To the 29d. Data signed (Month, Day, Year) 29b. Signature and hitle of certifier 29c. Licanse number 1998 D 23371 August () 12 30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print) m5s

Dr. Qamar Zaman-Johnson Height's Medical Building-Cumberland, MD 21502

31. Date filed (Month, Day, Year) Registrar

Aug 1 2 1998



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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Dev Yea **Physician** Ab. City, Town, or Location of Beath 4c. County of Deet 0519 GUY FRANCIS ORIGLIO /Medical 4e Facility Nama (If not institution, give street and number) 4c. County of Deeth **Examiner** PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Deta of Birth (Month, Dey, Year) **Funeral** Deys Months Hours NE M 2□ F Yrs 74 Director 197-16-4954 February 3, 1924 Philadelphia PA Usuel Residence of Decedent 10b. County 10c. City, Town or Location ral", or frame 23a or 28a-f show Examiner name be notified at 10d. Inside City Limits 1 Yes 2000 California San Diego County San Diego 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? D USA Funeral 301 92109 13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 4655 Lamont St., Apt 12. Was Decedant Evar in U.S. Armed Forces? Marine Layes 2 10 Corp. It Yes, Give Yaar or Datas: WWII 14. Race - American Indien, Bleck, Whita, etc. 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White à 3 ☐ Widowad 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Businass/Industry I Hygiene. Elamantery/Secondery (0-12) College (1-4or 5+) 12 4 Retired Scientist US Federal Government 17. Fethar's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frank Origlio Adeline 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Steta, Zip Code) Item 27 Maureen Origlio/Spouse 4655 Lamont St., Apt. 301, San Diego, CA 92109 20e. Method of Disposition 20b. Place of Disposition (Nama of cematary, crametory or other plece) Dete 20c. Location - City or Town, Stete 1 Buriel 2 Cremetion 3 Removel from Stete 4 Donetion 5 Other (Specify) = 8 parmit. Page Department of Important: If any Injury or 4 Donetion 8/23/98 Salisbury, Maryland Salisbury Crematory of Funeral Service Licensee 21. Sigt 22. Name and Address of Fecility M01051 Holloway Funeral Home Professional Association 501 Snow Hill Road, Salisbury, MD 21804 Hompoon 23a. Part1. Enter the diseesa, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each lina. Approximete Intarval Batween Onset and Death **Physician** /Medical Immedieta Causa (Final VENTRICULAR FIBRILLATION - holder disaasa or condition resulting in deeth) Examiner Due to (or es e consequence of) Examiner DRONARY ARTERY DISEASE Sequentielly list conditions, if eny, leeding to immadiate causa. Entar Underlying Causa (Disaasa or injury thet initieted evants resulting in deeth) Lest Due to (or es e consequence of): ere brovas cul Physician/Medical Dua to (or es e consequence of): 8/6/98 darleneito 2 Weekl Pert II. Other significant conditions contributing to deeth but not rasulting in the underlying cause given in Pert I. 23b, Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown HYPSRTENSION Completed by 24b. Wara eutopsy findings aveilable prior to completion of cause of deeth? LARGE CVA - lege Panietal - 6/98 24a. Wes an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No 25. Wes casa raferred to madical exeminar? Be 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) funeral 27. Mennar of Death 28b. Time of Injury 28d. Dascribe how injury occurred After ! 28c. Injury et Work? 5 Pending investigation 1-ENaturel Hospital or Attending 24 hours after death. Funeral Director: After stelling illed in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be datermined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicida 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29a. Cartifier

P.O. Records, Division of Vital Attending Physician:

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Box 68760.

Maryland

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Pages 1 and 2 should be nent of Health and Mental

Medical completaly within 2 To the

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29b. Signetura end title of certifier

31. Dete filed (Month, Dey, Year) AUG 2 1 1998

614 32. Registrer's Signeture

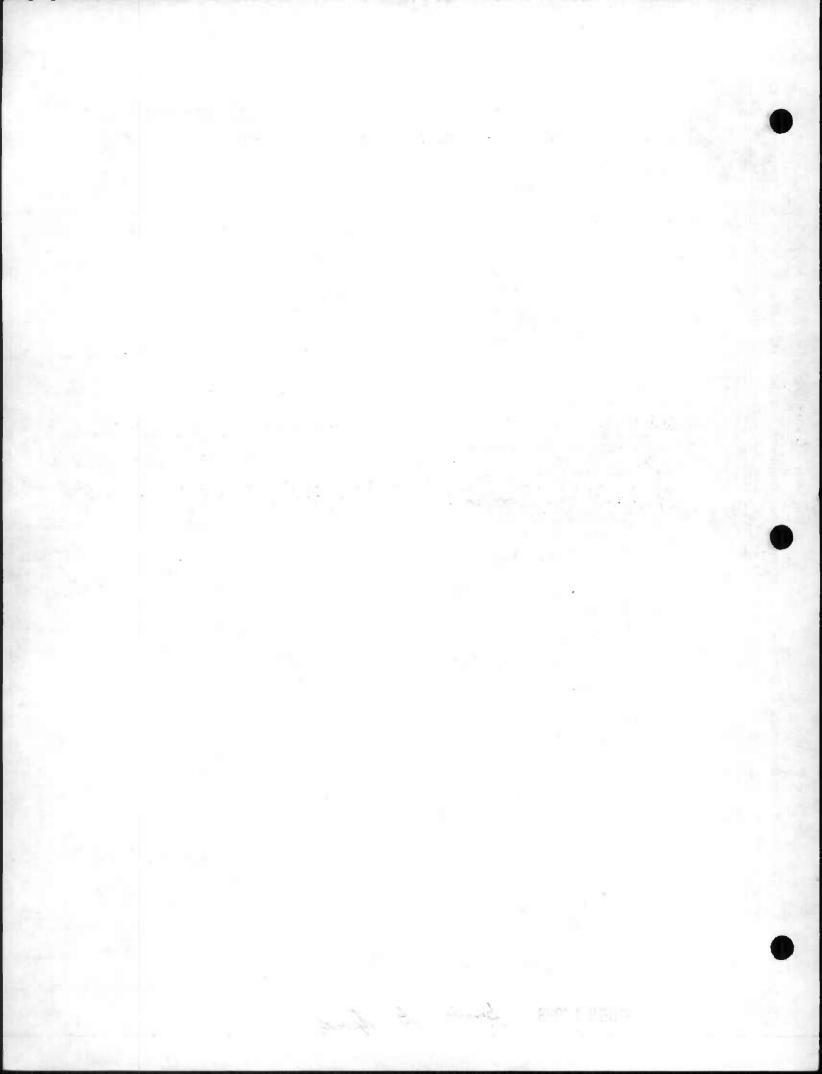
30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

29c. License number

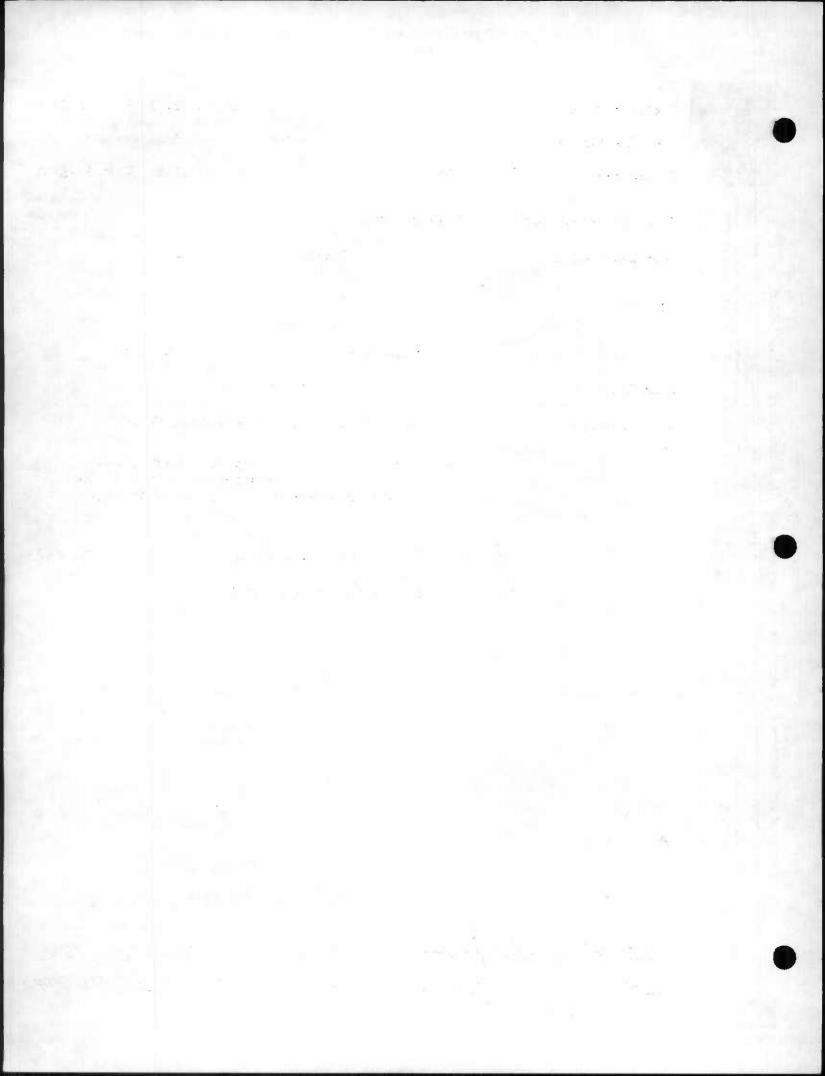
29d. Date signed (Month, Day, Year) 19

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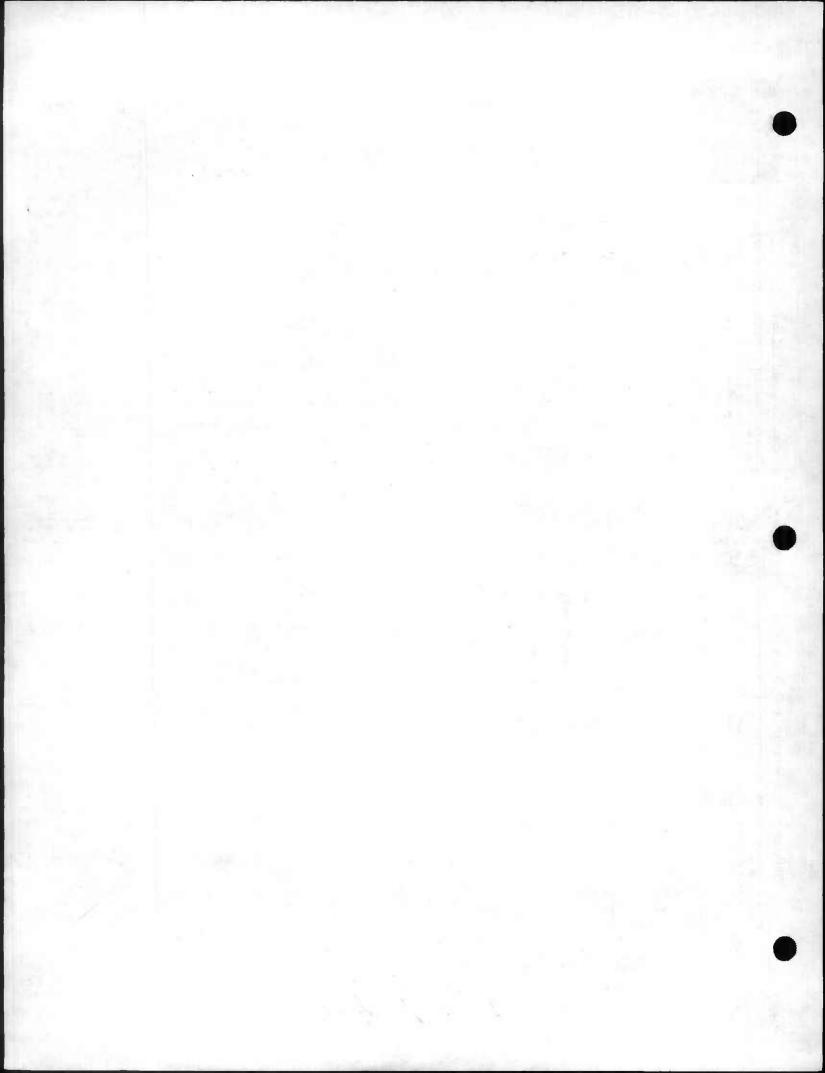
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ian cal	Gladys V. Osborn	ie					August	22, 19	98	8:3	5 AM
	4a Facility Nama (If not institution, gi	va street and number)			4	c. City, Town, or I	Location of Daath	4c. Count	y of Death		
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	299-20-4556	Sax 7. Ag 1□M 2፟M F	a (In yrs. last b	Yrs. If Unda Months	ar 1 Yaar 5 Days	If Under 24 Hrs. Hours Min.	8. Data of Birth (Month, Day Dec 9,	Yaar) 1911	9. Birthple Count West	Virg	or Foreig
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3	Maryland Montgo	omery	Silve	r Spring			1.	0- 04:	izan of What Country?		
Funeral Director	10e. Street and Number 2805 Red Lion Lr				ip Coda 2090	·		USA			
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	19a. Informant's Name/Ralationship	(Typa, Print)					iral Routa Numbe			Code)	
	Don Marple/Son					Ln, Silv	ver Spri	ng, MD	20904		
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	W Burial 2 ☐ Cremation 3 [4 ☐ Donation 5 ☐ Other (Speci		Broo	kdale Ce	meter	v	Aug 26	Elyria	. Ohi	0	
	21. Signature of Funaral Sarvice Lice	nsaa	DLOO				nes-Rina				
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Dey Month **Physician** VIOLET ELIZABETH POPP AUGUST 16 1998 1:11 PM /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Saint Joseph Medical Center Towson Baltimore 7. Age (In yrs. last birthday) If Under 1 Year Months Days If Under 24 Hrs 8. Dete of Birth (Month, Day, Year) Jun 28, 1924 Birthplece (State or Foreign Country)
 MD 5. Social Security Number **Funeral** Days 10M XOF Hours Yrs 219-14-7397 74 Director Usual Residence of Deceden 10a State 10b. County t0c. City, Town or Location t 0d. Inside City Limits than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at the Maryla X Yes 2 No Cumberland Directo Allegany 10a Street and Number 10f Zin Code 10g. Citizen of What Country? 12350 Williams Road USA 21502 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 72 hours after Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes X No Specify: Specify 3 3 ☐ Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) t6b. Kind of Business/Industry permit. Papes 1 and 2 should be illed within 72. Department of Health and Mental Hygiens, important: if flem 27 is marked other than "nah any injury or other traumatic event, the Medica once. Elementary/Secondary (0-12) College (1-4or 5+) Medical Mission Retired Missionary 17 Father's Name (First Middle Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) 8 William McKinley Popp, Sr. Violet V. (Duckworth) 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t9a. Informent's Neme/Reletionship (Type, Print) 12350 Williams Road Cumberland MD 21502 V. Marlene Popp-sister 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State Sunset Memorial Park 4 □ Donation 5 □ Other (Specify) 08/20 Cumberland MD 21. Signeture of Funeral Service Licen-22. Name and Address of Facility
Scarpelli Funeral Home, P.A. Cumberland MD 21502 plications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, Approximate Intervel Between Onset end Death 23a. Pertt. Enter the disease, or companies shock, or heart feilure. List only **Physician** CARDIAC ARREST 1ST MI /Medical Immediate Cause (Final disease or condition resulting in death) Examine Due to (or es a consequence of) SECONDARY TO MYOCARDIAL INFARCTION 1 WEEK Examine ettending physician and for use as the burlef-transit Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): SND WI (PROBABLY SECOND OF TWO) Box 68760. certificate be Physician/Medical Due to (or es a consequence of): IMMEDIATE ed by the e 23b. Did lobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed by tehould be detect 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed 188 2 X No t ☐ Yes 2 ☐ No certificate of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Manpatient 2 □ ER/Outpatienf 3 □ DOA 2 this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 5 Pending investigation Division death. 1 ☐ Yes 2 ☐ No after death Director: / d in by the f 2 ☐ Accident 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital o within 24 hours af To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end plece, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified D29301 MD 8-17-98 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nes 2205 YORK ROAD. KATE TULLY, M.D., TIMONIUM. MARYLAND 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 1 8 1998 Registrar parks

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 27455 Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month Day **Physician** Mary E. Pello August 26, 1998 21:08 PM /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery General Hospital Olney
If Under 24 Hrs. Montgomery Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Funeral Days Hours 1□ M 2☑ F Months Director 578-18-4845 June 10,1920 Washington, D.C. Usual Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location 10d Inside City Limits r than "natural", or flems 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S.
Armed Forces? 14809 Pennfield Circle Funeral 20906 USA Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 1 ☐ Never Merried 2 ☑ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify. by 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Peges 1 end 2 should be filed within nent of Heelth and Mental Hygiene. int: If Itam 27 is marked other than * College (1-4or 5+) Elementary/Secondary (0-12) Procurement Analyst Federal Government 18. Mother's Name (First, Middle, Meiden Sumame) 17. Father's Neme (First, Middle, Last) Daniel Finnegan Mary Tripplet 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 19a. Informent's Neme/Reletionship (Type, Print) nt of Heelth a : If ham 27 is or other tra Michael A. Pello (Husband) 14809 Pennfield Circle #208 Silver Spring, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State Date permit. Peges 1 Department of H important: If Ital any injury or oth pace. 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Gate of Heaven Cemetery |8/31/98| Silver Spring, Maryland 22. Name end Address of Fecility
Francis J. Collins Funeral Home, Inc. 21. Signature of Funeral Service Licenses auh 500 University Blvd., W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death Physician /Medical Immediate Ceuse (Finel disease or condition resulting in death) DAYS Preumonia Examiner Due to (or as e consequence of): Examiner MSPIR MYOL RECUERENT 4 em physician and s the burial-transit the death certificate be axecuted Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical Due to (or as e consequence of): Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown hydrocep halus DNISURE þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed U.RO Sepsis 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: 1 Anpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No this 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident Division Attending 5 Pending Investigation To the Hospital or Attendit within 24 hours after death. To the Funeral Director: At completely filled in by the fu death. 1 ☐ Yes 2 ☐ No

P.O. Records, of Vital

6 Could not be determined

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29c. License number 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier a. Kraai Mo

1)24543

August 27, 1998

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

3305 NONTH LEISUR WORLD BLYD, SIEVER SPRING MD 20905 James A. ROSSI, MD 31. Dete filed (Month, Dey, Year)

State Registrar

edical

3 Suicide

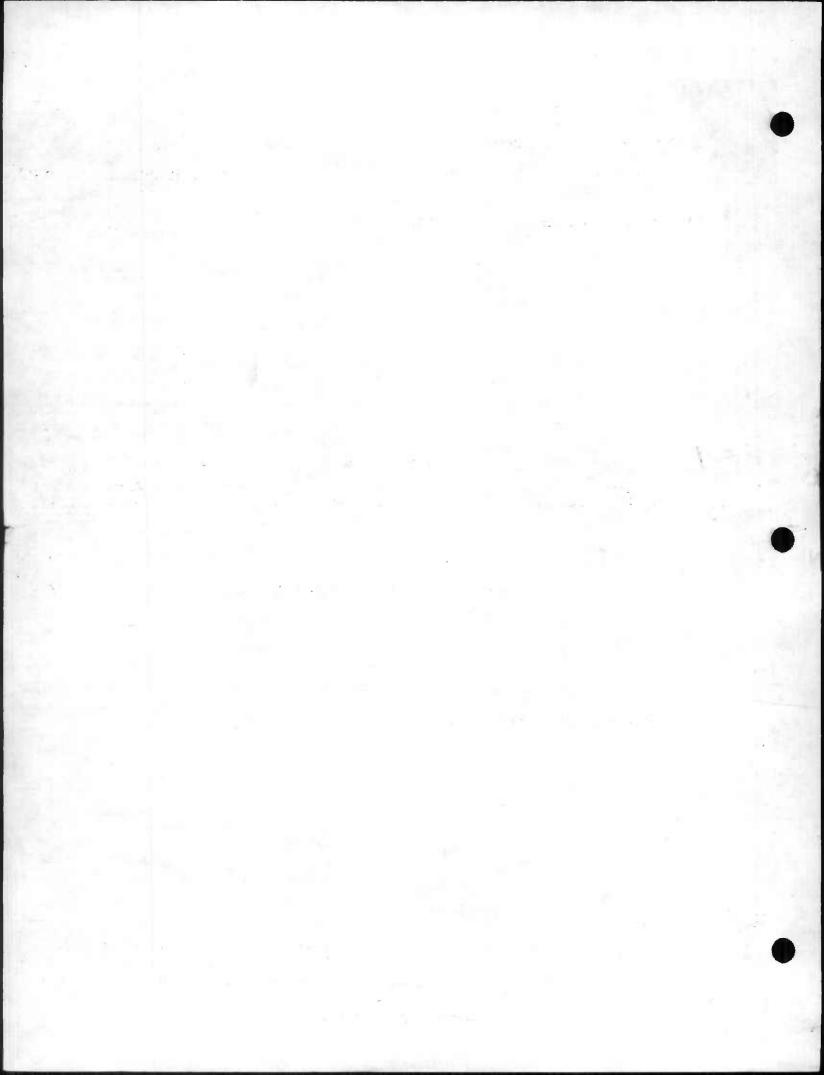
29a. Certifier

4 ☐ Homicide

(Check only one)

AUG 28 1998

32. Registrer's Signature

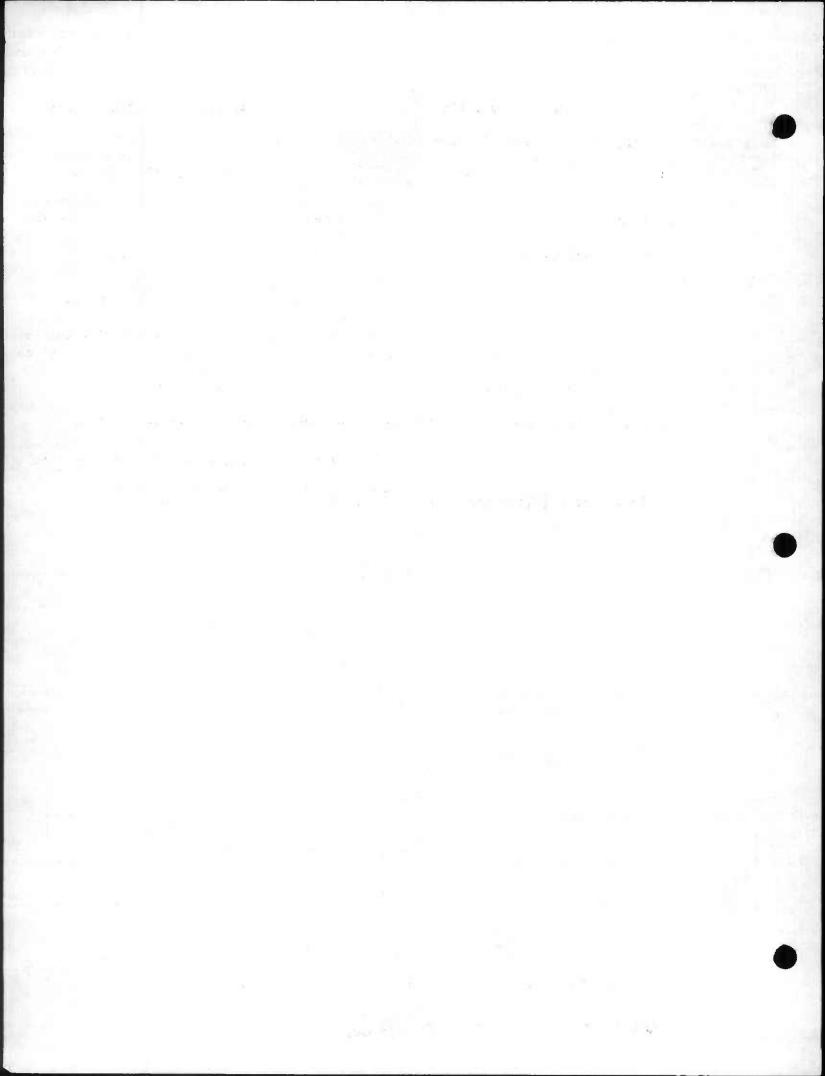


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 8 2 7 4 5 6 Certificate of Death

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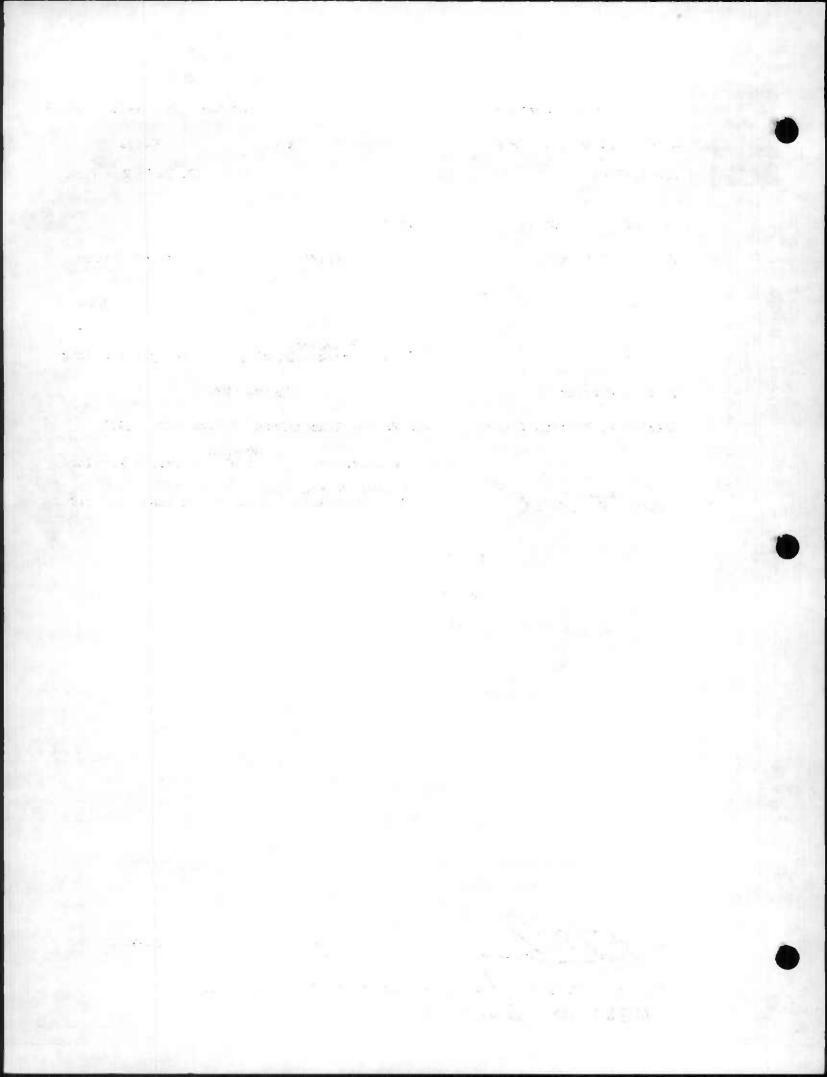


State of Maryland / Department of Health and Mental Hygiene

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cal ner	te Facility Neme (If not institution, given Laurelwood Nursi 5. Social Security Number 6. 5.	ve street end number) ng Center				4	b. City, Town	Au	gust	28	1998	13:55
ner 4	Laurelwood Nursi 5. Social Security Number 6.5	ng Center				4	b. City, Town	, or Location	n of Death	4c. County	of Death	
	5. Social Security Number 6. S											
	5. Social Security Number 6. S						Elkto	วท		Ce	cil	
-	116-12-3103	7. Ag	e (In yrs. last I	birthdey)		1 Year	If Under 24	Hrs. 8. D	ate of Birth		9. Birthp	lace (Stete or Fo
-		1⊠M 2□F	91	Yrs.	Months	Deys	Hours	Min. (A	Nonth, Day,	3. 1907	New	York
	Usual Residence of Decadent											
	10a. State 10b. County		10c. City, To	wn or Loc	cation						11	0d. Inside City L
ō.	Maryland C	ecil		E1kto	on							1 X Yes 2[
X	10e. Street and Number	CCII		Direc	10f. Zip	Code			1	0g. Citizen of 1	What Coun	try?
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Funeral	100 Laurel Drive	12. Wes Decedent	Ever In U.S.	13 W	Ves Dece			7 (Specify)	es or No-		a - Americ	
5	1 ☐ Never Married 2 ☒ Married	Armed Forces? 1 ☐ Yes 2 ☑ !		If	Yes, spe	cify Cube	ispanic Origin n, Mexican, F	Puerto Rican	, etc.)	Bie	ck, White,	etc.
by F	3 Widowed 4 Divorced	If Yes, Give Year or Detes:	10	1	☐ Yes	2 🖾 No	Specify:			Specify	v: Wh	nite
8	15. Decedent'a E		16	Sa. Decede	ent's Heur	al Occup	ation			16b. Kind of B		
Completed	(Specify only highest gra	ade completed)		(Give 1	kind of wa	ork done	duning most o	f working		TOO. TRITICO D	00110001110	20 Oct y
g.	Elementery/Secondary (0-12)	College (1-4or 5	_				iouse	1 11		Emodah	е Тэв.	al-dma
	17 Cathor's Name /First Middle I set	*1	ע	rive	r	reig	tht Har			Freigh		cking
m	17. Father's Neme (First, Middle, Last	9					20			Maiden Sumen	10)	
9	Charles Pertain						9	aret C				
	19a. Informant's Name/Relationship ((Type, Print)	11	9b. Mailln	g Address	s (Street	and Number	or Rural Rou	rte Number	, City or Town,	Stete, Zip	Code)
	Charles E. Perta	in / Son					nool_Ro	oad, E	1kton	, MD	21921	
- 3	20a. Method of Disposition	70	20b. Place ceme	of Dispos	sition (Name	me of other plea	e)	Da		20c. Location	City or To	wn, State
-	1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special			bank				Aug 199	8 6	alvert	Mar	vland
d a d	21. Signaturg Funeral Service Lice		Rose				ss of Facility	, 100	0 10	aivere	, 1141) Tana
	1/1/2/11						eral Ho					
	Koled . M	rel								h East	, MD	21901
	23a. Part1. Enter the disease, or com shock, or heert failure. List only	nplications that caused one cause on each li	I the deeth. D	o not ente	er the mod	de ot dyin	g, such as ca	ardiac or res	piratory arr	951,	1	Approximete Interval Between
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	Immediate Cause (Finel disease or condition	C	1D								1	
	resulting in deeth)	a	Due to (or es	e consequ	uence of):	:						
Je l		1	HN									
Examiner	Sequentially list conditions	b	Due to (or es	e consequ	uence of):							
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	0	VA									
Medical	cause. Enter Underlying Cause (Diseese or injury that initiated events	c	Due to (or as	e consequ	ience of).							
g	resulting in death) Last		D00 10 (01 03 1	o consoqu	Jonioa Oi).							
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Physician	Part II. Other eignificant conditions	contributing to death b	ut not resulting	g in the un	nderlyling	cause giv	en in Pert I.					the cause of
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by											045 111	
Completed								3	24a. Was a perfori		ava	ere autopsy fine aliable prior to
ple												mpletion of cau death?
EO									1 🗆 Y	es 25kNo	1	Yes 2 N
	25. Was case referred to medical						26 Place o	of Deeth (Ch				
00	examiner?	Hospitel:	ant officer	Outpotters	بم الله	Oth	or:				or /Co-si	141
5	1 ☐ Yes 2 No 27. Manner of Death	1 Inpatie		Outpetient o. Time of		UA	4 QQ INUIS			once 6 Oth		y)
O	1 ⊠ Naturai 5 ☐ Pending	(Month, Da	y Year)	Injury	м	28c. injur Wor	k? Yes 2 □ No		2.20	,, 0000		
Certification:	2 Accident Investigation 3 Suicide 6 Could not be	20		Annua :			, oo z LINC		anation /A	tenat and the	har as D	Doute Must
ŧ	4 Homicide determined	289. Place of Inj	jury - At home, c. (Specify)	ramn, stre	et, tactor	y, offica			City or Town		ver or mure	il Route Numbe
	(Check only 2 Medical Exam	hysician: To the best miner: On the besis of	f examinetion									
Cal	one)	and menner st	ated.									
edica		1			29		e number		2	9d. Date signe		Dey, Year)
	29b. Signature end title of confider	100				D32	195			08-3	31-98	
	29b. Signature end title of corline	1/2				DJZ	333		(00 0		
Σ	16/8	completed cause of d	leath (Item 23s	a) (Type, F	Print)	D32					. 30	
Σ	29b. Signature end title describer 30. Name end eddress of person who Thomas E. Finu		death (Item 23a					MD 2	1901			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death **Physician** Month Year Mary E. Pinkney August 7:26 AM 26 1998 /Medical Eacility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Medical lata enter harles · IUISTA If Under 1 7. Age (In yrs. last birthday) If Under 24 Hrs. 5. Social Security Number Year Birthplace (Stete or Foreign Country) Deys Hours 1□ M 2□ F Yrs. 577-50-2884 63 June 27, 1935 Washington, D.C. Usuel Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Directo Maryland Charles Brandywine 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 15110 Regina Avenue 20613 Funeral USA 12. Wes Decedent Ever In U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 □ Never Merried 2 □ Married 1 ☐ Yes 2 No Specify: Completed by Specify: Black 3 □ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Surneme) Be Andrew Gray Bessie Gray 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Patrick Pinkney- Son 15110 Regina Avenue Brandywine, Maryland 20613 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, Stete Burial 2 Cremetion 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Gibbons Cemetery August 31,1998 Brandywine, Maryland L Funeral Service Licenses 22. Neme end Address of Fecility Adams Funeral Home Aquasco, Maryland 20608 23e. Pert1. Enter the disease, or complications that caused to deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heer tailure. List only one cause on each line. Approximete Interval Between Onset and Deeth Immediate Cause (Final disease or condition resulting in deeth) MADURY TTC CAADIOUASCULAM OII: DISEASE Sequentielly list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequence of). Due to (or es e consequenca of) Pert II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveltable prior to completion of ceuse of deeth? 24e. Wes en eutopsy performed? 1□ Yes 2 No 25. Was cese referred to medicel examiner? 26. Plece of Deeth (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Deeth 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 Neturel 5 Pending

The law requires that the death certificete be executed Box 68760, attending physician Physician/Medical the P.O. ate has been signed by page 2 should be detec Division of Vital Records. þ Completed this certificate al or Attending Physicien: The safter death.

In Director: After this certificate of in by the funeral director, pa Be To Certification:

Funeral

Director

Nems 23a or 28a-f show

9

traumatic event, the Medical Examiner

Pages 1 and 2 should be filed within nent of Heelth end Mental Hygiene. int: if Item 27 is marked other than

permit. Pages 1 and 2: Department of Heelth er Important: If Item 27 is any Injury or other trau

Physician

/Medical

Examiner

1 Yes 2 No investigetion 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 1 Certifying Phyeician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete end plece, end due to the cause(s) end menner steted.

29b. Signeture end title of cartifier

29e, Certifier

29c. License number -18545 29d. Dete signed (Month, Dey, Year)

adress of person who completed cause of deeth (Item 23a) (Type, Print)

12070 Old Line Centre #207 Waldorf, MD Philip Wisotsky 31. Dete filed (Month, Dey, Year)

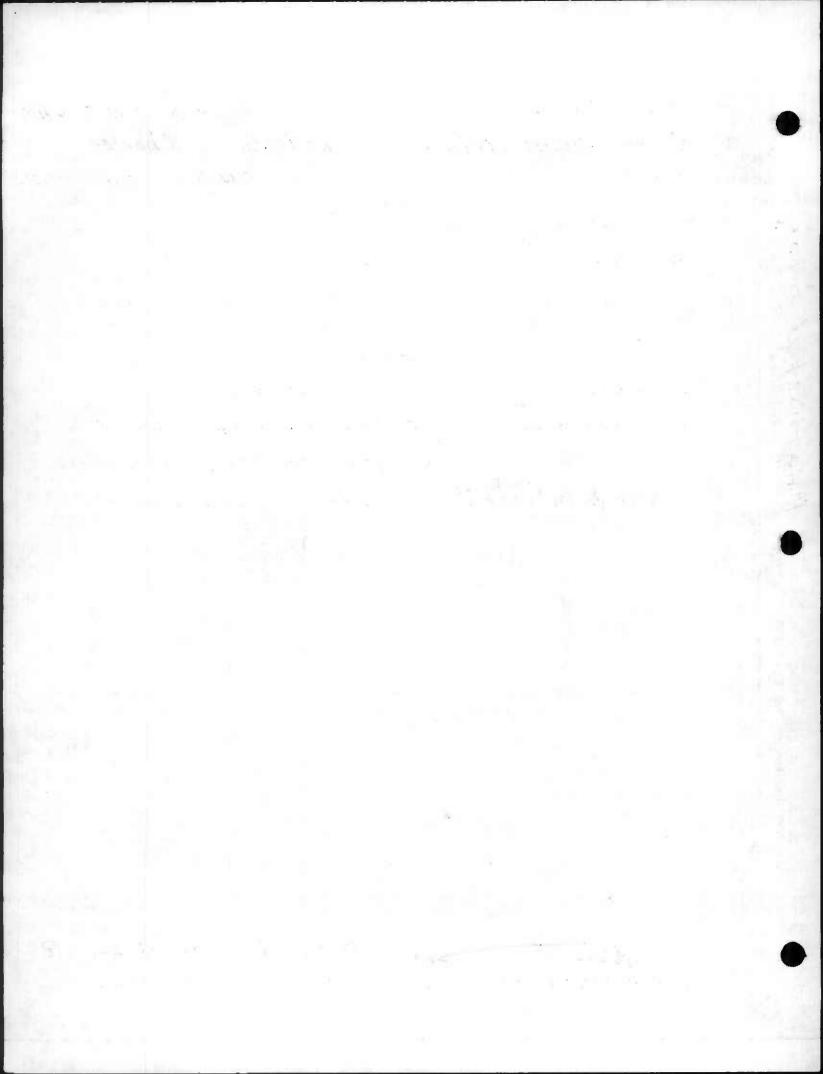
State Registrar

Medical

32. Registrar's Signature AUG 28



To the Hospital or within 24 hours aft To the Funeral Di completely filled in



Certificate of Death

Physician /Medical Examiner

WILLIAM THEODORE 4e. Fecility Neme (If not institution, give street and number)

HOSPITAL

1 XM 2□ F

1. Decedenl's Neme (First, Middle, Last)

MEMORIAL

5. Sociel Security Number

193-07-5523

REMBOLD

7. Age (In yrs. last birthday)

Yrs.

92

2. Dete of Deeth Month AUG.

11:37 PM

10d. Inside City Limits

1 Yes 2 No

4b. City, Town, or Location of Death

4c. County of Deeth ALLEGANY

CUMBERLAND If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)

Funeral Director

10

31. Dete filed (Month, Dey, Year) AUG 2 1 1998 Registrar

PHILIP SCHRUENER

32. Registrer's Signeture

G. Sports

 Race - American Indian, Black, White, etc. Specify: WHITE

USA

FARM

18. Mother's Name (First, Middle, Meiden Surname) KENDALL

REMBOLD RD. MEYERSDALE PA

20c. Location - City or Town, Stete

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth?

1 Yes 2 No

24 Hours

1 ☐ Yes 2 ☐ No

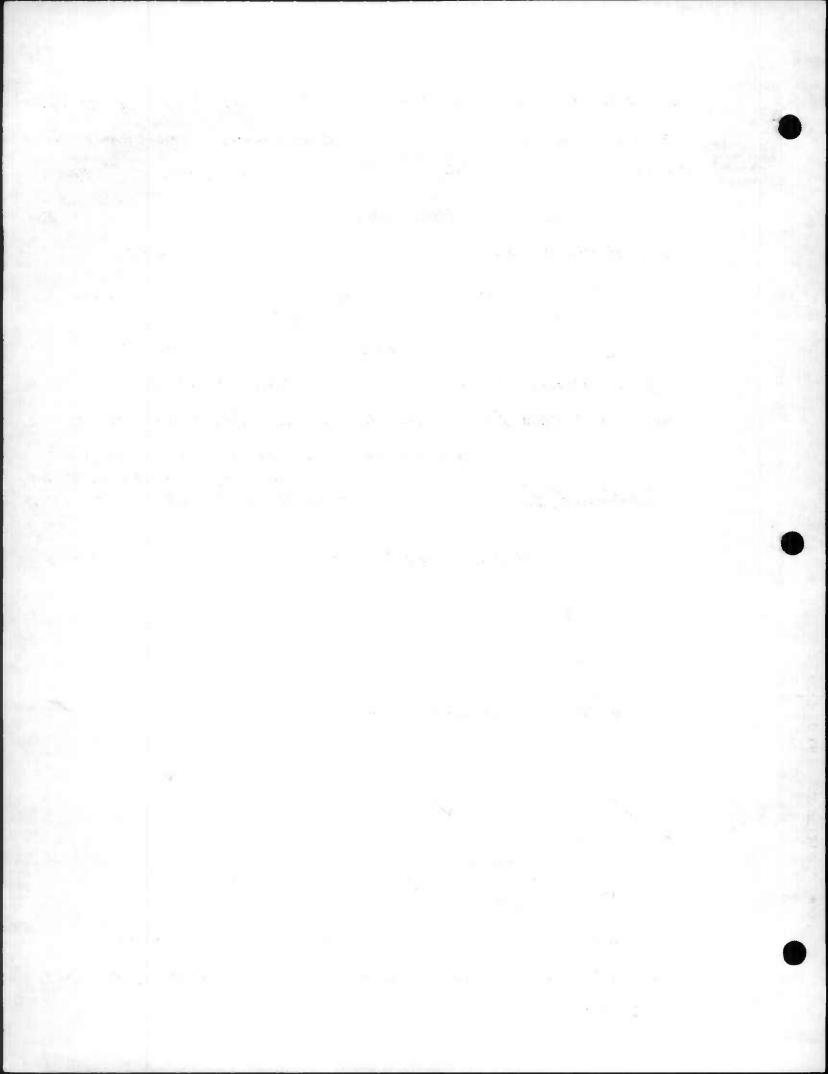
Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Dey, Year)

Papera



													P	leg. No.			
sician	1. D	ecedent's Na	me (First, Mi	ddle, Last)									ate of Dea Month	th Day	Year	1	Time of Death
edical		LOUIS	A. R	ATTEN	NI									16, 199			:50 P.N
miner	4a F	acility Name	(If not institu	tion, give s	street and nu	im <i>ber)</i>					4b. City, Tow	n, or Location	n of Death	4c. County	of De	ath	
	Me	morial	Hosp								Cumber			Alleg	any		
ral		ocial Security		6. Sex	M 2 F			ast birthday) Yrs.	Months	Days	Hours Hours	Min. (A	ate of Birth Month, Day	Year)	9. B	rthplace (State or Foreig
or		39-16- al Residenca		Λ-		81	•	115.				Aı	ug 4,	1917	I	RI	
		State	10b. Cou	nty		1	10c. City,	, Town or Lo	ocation							10d. In	side City Limit
al Director	M	D	Alle	ranu			C	lumber	land							X	Yes 2 N
Director		Street end N		Jaily				Julioca	10f. Zip	Code			1	I0g. Citizen of \	What C	Country?	
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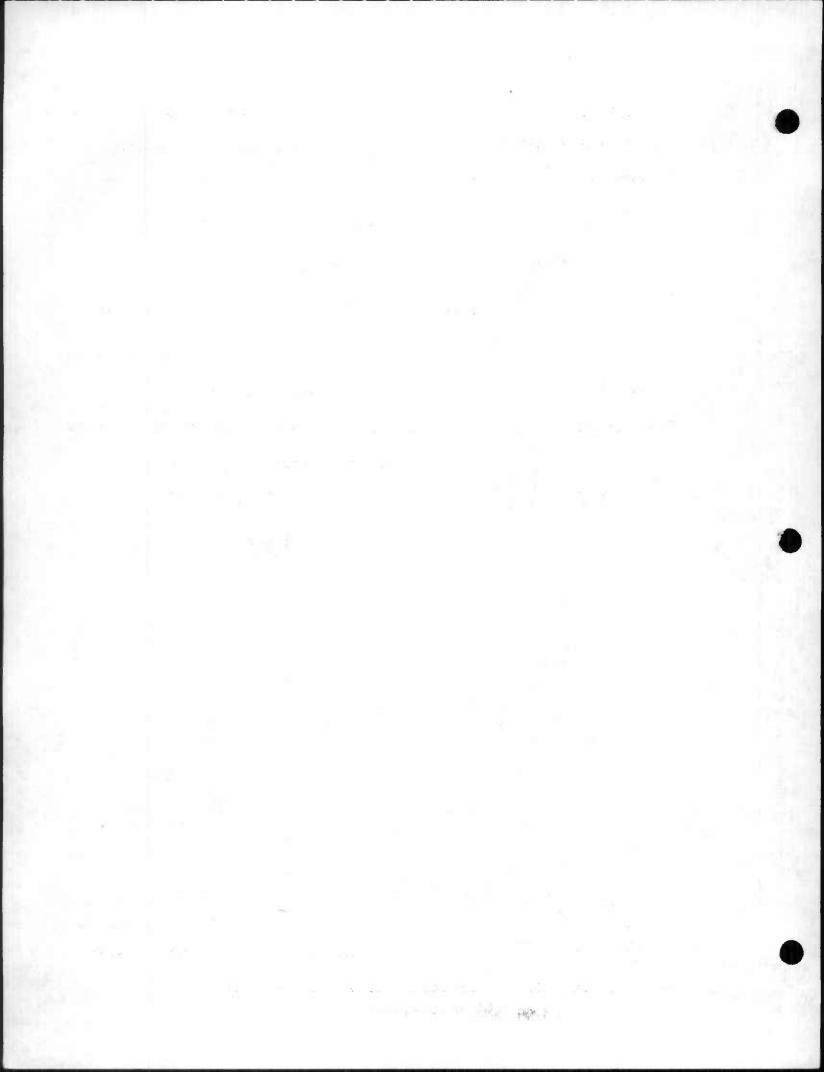
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LOUIS RATTENNI

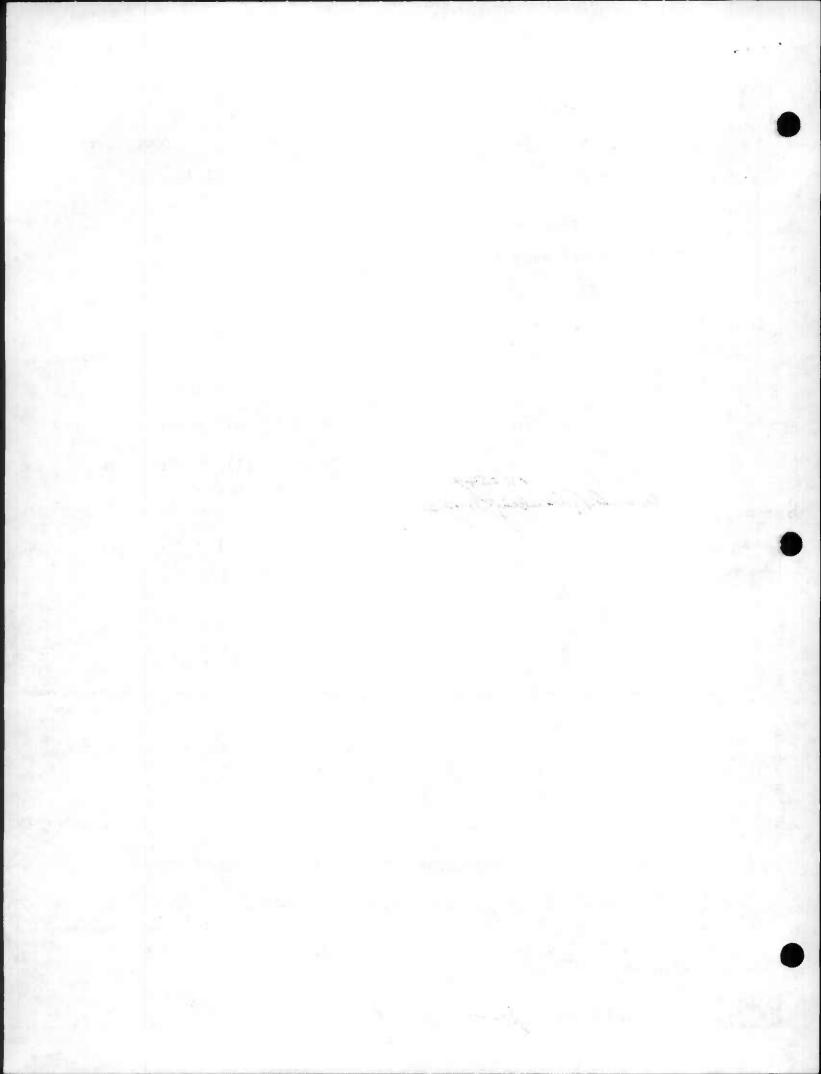
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

					Cei	rtificate o	f Death	R	eg. No.	-	1403
Physic	ion	1. Decedent's Name (First, Middle, Li	ast)					2. Date of Daat Month		Yeer	3. Time of Death
Physic /Med		Roberta Wall	ach Ryar	1				August	9, 19	98	1:50am
Exami		4a. Facility Name (If not Institution, gi)			4b. City, Town, or I		4c. County	of Deeth	
		10500 Rockvill					Rockvi	_	Mont		
Funeral Director	_	003-26-8317	Sex 7. A 1 □ M 2 ☑ F	ge (In yrs. lest	birthday) Yrs.	If Under 1 Year Months Day		8. Dete of Birth (Month, Day, April	Year) 13, 15	9. Birthp Cour 3 8	place (State or Foreign ntry) PA
and w	1	Usual Residence of Decedent 10a. Stata 10b. County		10c. City, T	own or Lo	ocation				1	10d. Inside City Limits
Aaryti Fsho	6										1 ☐ Yes 2 ☑ No
the the	Director	10e. Street and Number	ngton	N/A		10f. Zip Code		1	0g. Citizen of V	What Cour	nt2
with		1301 N. Courth	D.J					"			nry r
leath me 23	era	11. Maritai Status	12. Was Decedent		13 1	2 2 2 Was Decedent of		necify Yes or No-	U.S.		cen indian.
d 2 should be filed within 72 hours efter death with the Maryland of 2 should be filed within 72 hours efter death with the Maryland the and Mental Hyglene. 7 Is marked other than "natural", or items 23s or 28s-f show traumatic event, its Moorcal Examines must be notified.	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces 1 Yes 2 If Yas, Give Year or Datas:	? {No		if Yes, specify Cu 1□ Yes 2 1 N	Hispanic Origin? (Suban, Mexicen, Puerto o Specify:	o Rican, etc.)	Bled	k, White, White	etc.
72 ho	ted	15. Decedent's E (Specify only highest gr	ducation	1	6e. Deced	dent's Usuai Occ	upation	leim -	16b. Kind of Bu	usiness/inc	dustry
within viene.	Completed	Elementary/Secondary (0-12)	Collaga (1-4or	5+)	life.	DO NOT use reti	ne during most of wor red)	King			
Hygien ther th	S		5+		Atto	orney					rvices
d 2 should be filled th end Mental Hygi 7 Is marked other traumatic event,	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle, N	Aaiden Surnam	e)	
should be and Mental marked o	2	Louis Spekin					Frances	Shapi	ro		
2 sho		19a. Informant's Name/Relationship					et and Number or Ru				
is 1 end 2 of Health Item 27 I		Edward Wallach	/Son				onfield				
		20a. Method of Disposition 1 ☐ Buriai 2 ☐ Cremation 3 ☐	Removel from State	20b. Place ceme	of Dispo etery, crem	sition (Neme of matory or other p	lace)	Date :	20c. Location -	City or To	wn, Stete
permit. Pages 1 en Depertment of Heal Important: if Item 2 any injury or other once.		4 Donation 5 □ Other (Speci	(y)	Jude	an M	ſem. Gd	ns.	3/11/98	01nev	. MT)
Depertimonts any infinite.		21. Signature of Funeral Service Lice	nsea MOOS	44	22	. Name and Add	Iress of Facility				
88588		10 DK	0 0	1.	2.0	lves-	Pearson	Funeral	1 Home		
		23a Part 1 Enter the disease or con	enlingtions the rouse	d the death [Z C	or the mode of d	son Blyd	l. Arli	ngton,	VA	22201
		23a. Pert1. Enter the diseese, or con shock, or haart failure. List only	one cause on each I	ine.	o not ent	el the mode of o	ying, such as cardiac	or respiratory arre	est,		Approximete Interval Between Onset and Death
Physician /Medical		Immediate Course (Final	3.1	N. J.						1	Onset and Death
Examiner		immediata Ceuse (Final disease or condition resulting in death)	. Oval	2,AN	CP	+				10	x year)
	L	resulting in death)		Due to (or as		quence of):					
Si od	ine		h							1	
eath certificate be executed ettending physicien and for use as the buriel-trensit	Examiner	Sequentially list conditions,		Due to (or as	a conseq	juance of):					
ficete be ex physicien as the buriel		Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disaase or Injury	6							- !	
sete b	edical	that Initiated events resulting in death) Last	0.	Due to (or as	a conseq	uence of):					
ing p	2										
ettending for use	an/		d								
ires thet the death cersigned by the ettending be deteched for use	Physician/	Part il. Other eignificant conditions o	ontributing to death b	out not resulting	g in the ur	nderlying cause (given in Part I.	23b. Did to	bacco use cor	ntribute to	o the cause of death?
d by the	Phy							1 🗆 Ye	2 No	3 Prol	bably 4 Unknown
es thet igned b	by I										
been	Completed							24a. Wes ar perform		ave co	era autopsy findings eilable prior to mpletion of ceuse death?
The levele hes	E							1□ Ye	s 2 No	1.	Tyes 2□ No
ician: The certificete rector, pag	Be C	25. Was case referred to medical					26 Place of Dog	th (Check only one			2,110
Physician: rthis certifice	ToB	exa <i>m</i> iner? 1 ☐ Yes 2점 No	Hospital:	oot 20 ED/	Outpatien	t 3 DOA				10	
Phy gral o		27. Mannar of Death	28a. Date of Inju (Month, Da		o. Time of		ury at	28d. Dascribe ho	w Injury occurr	ed (Specif)	Secondar
I or Attending efter deeth. Director: After d in by the fune	tion	1 Natural 5 Pending investigatio		y Year)	Injury		ork? ☐ Yes 2 ☐ No			-	
or Attending efter deeth. Director: After I in by the fune	fica	3 ☐ Suicide 6 ☐ Could not b	e 00- Di(1-)	iury - At home	farm etre	eet, factory, office		28f. Location (Sti	reet and Numb	er or Rura	al Route Number
or A efter Direction	Certification:	4 ☐ Homicide determined		c. (Specify)	idilli, ott	oot, lactory, office		City or Town		0, 0, 1,0,0	11001011011
To the Hospital or Attending Phywithin 24 hours effer deeth. To the Furerel Director: After this completely filled in by the funeral		29a. Cartifier 1☆ Certifying Pt	velelen. To the best	of our longuists	lan danih		Ai 4-A 4-1	1 1 1 - 1 - 1			
Hospita 24 hours Funerel stely filled	edical		ysician: To the best niner: On the basis o	f axamination	and/or inv	estigation, in my	ropinion, death occur	red at tha tima, da	iuse(s) and ma ata and place, a	nnar as st and due to	the ceuse(s)
To the To the comple	Me	29b. Signature end title of certifier	and manner st	ateo.	_	20c Licer	nse number	26	d. Date signed	1 /Month	Day Veer)
						~				4	Day, reary
12						n	C2131		8/19/	75	
		30. Name and address of person who	completed ceuse of o	death (item 23a	a) (Type,	Print)			007 6	100	
		Bill Dahut 380	00 Reser	voir F	Rd.N	W Wash:	ington,	D.C. 20	007-2	19/	
Sta	ate	31. Date filed (Month, Day, Year)	32 Registr	rar's Signature	1	1					
Regist	rar	AUG 2 5 1998	some	w /	9.	South.	/				

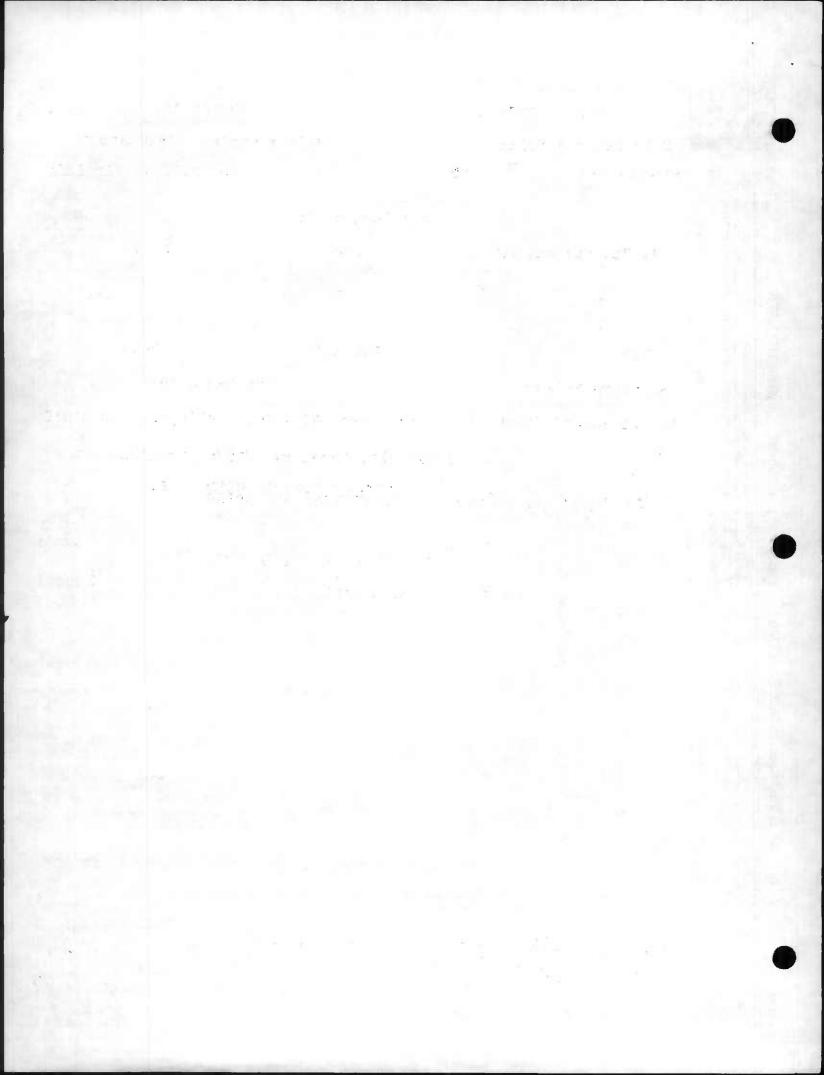


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Deeth Month **Physician** 4:50 AM AUGUST 19, 1998 RUSSELL BESSIE /Medical 4a Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner MONTGOMERY Silver Spring Holy Cross Hospital 8. Date of Birth (Month, Day, Year)

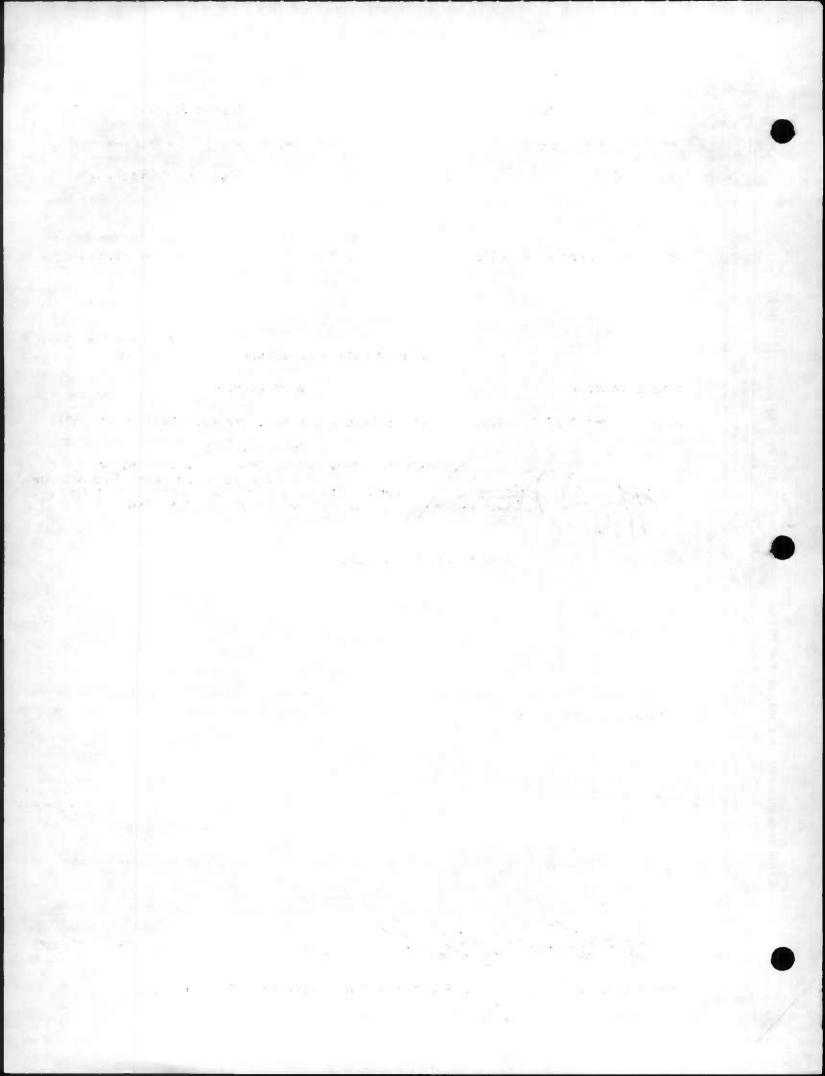
2,1907 if Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthdey) 9. Birthplece (State or Foreign **Funeral** 1□ M 2▼F Months Deys Hours Min. Virginia 91 Yrs. 579-30-8454 Director Usual Residence of Decedant the Marylend 10e State 10b. County 10c. City. Town or Location 10d. Inside City Limits lem 27 is marked other than "natural", or flems 23a or 28a-1 show other traumstic event, the Medical Examinat must be notified at 1X Yes 2 No Director Washington, 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? With U.S.A. 20012 7129 7th Street, NW Funeral death 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 2 should be filed within 72 hours after on and Mentel Hygiene.
Is marked other than "natural", or item 1 Yes 2 No If Yes, Give Year or Detes: 1 □ Never Married 2 □ Married T € Baltimore, Maryland 21215-0020 Specify: Black 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Hygiene. Elamantary/Secondary (0-12) College (1-4or 5+) Home Domestic 7th 18. Mother's Nama (First, Middla, Maiden Surname) 17. Father's Neme (First, Middle, Last) Cora Randolph Shephard Walker 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) permit. Pages 1 end 2 sh Department of Health and Important: If Item 27 Is m any Injury or other traum pncs. 1909 Park Rd., NW, Washington, DC 20010 Robert Howard (Nephew) 20b. Placa of Disposition (Name of cemetary, crematory or other place) Date 20c. Location - City or Town, Stete 20e. Method of Disposition Muriai 2 Cremation 3 Removal from State Cedar Hill Cemetery 8/29/98 Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Uconsec 22. Nama end Address of Fecility SNOWDEN FUNERAL HOME, ROCKVILLE, MD 20850 or combilications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, List only one cause on each line. 23a. Part 1. Enter that Approximata Intervai Batween Onset and Death **Physician** Zwecks /Medical Immediete Cause (Final disease or condition resulting in death) Examiner Examiner occurd certificate be executed ician and buriei-tran Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consed physician s the burie Box 68760 Physician/Medicai Due to (or es e consequence of): 98 use for P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 94 P 1 Yes 2 Nb 3 Probably 4 Unknown signed b Division of Vital Records. þ 24b. Were eutopsy tindings available prior to 24e. Was en eutopsy performed? Completed completion of cause of death? page 2 s has certificate 1 Yes 2 No 1 □ Yes 2 □ No director. 26. Placa of Daath (Check only one) Be 25. Was case raterred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 inpatient 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury (Month, Day Year) funeral 28d. Describe how injury occurred 27. Manner of Death 28b Time of 28c. Injury et Work? Certification: After Attending 1 DNatural 5 Pending after death. 1 Tes 2 No investigation 2 Accident 6 Could not be determined 281. Location (Straat and Number or Rural Route Number, City or Town, State) 3 ☐ Sulcida 28e. Place of Injury - At homa, farm, street, factory, offica building, etc. (Specify) 3 4 Homicide ò filled in Hospital 24 hours 29a. Certifier 1 Certifying Physician: To tha best of my knowledga, death occurred et the time, date and pleca, end due to the causa(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, data end pleca, end dua to the cause(s) and manner stated. (Check only one) To the I within 2 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) cause of death (Itam 23a) (Type, Print)

State Registrar



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				Certificat	e of	Death			Reg. No.		
	1. Decedent's Name (First, Middle,	.ast)	CAPTURE.	CERTIFIED I				2. Dete of Dec	ith	Veer	3. Tima of Death
Physician	Anna Louise	Reichert						Month August	23, 199	Yeer 98	6:05 PM
/Medical Examiner	4e Fecility Name (If not institution, g	ive street end number,)			4b. City, To		cation of Deeth			
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Funeral		Sex 7. A	ge (In yrs. lest birt	hday) If Unde	r 1 Yaar Deys			8. Dete of Birti (Month, De			ece (Stete or Foreig
Director	144-22-5753 Usuel Residence of Decedent	1□M 2∏F	69	Yrs. Months	Deys	Hours	Will.	April :	2, 1929	Penns	ylvania
yland	10a. Stete 10b. County		10c. City, Town	or Location						10	d. Insida City Limits
Mer To	New Jersey Mercer		Ewing	3							1 ☐ Yes 2 ☒ No
r 286	10e. Street end Number	10-1-1		10f. Zi	Code				10g. Citizen of V	Vhet Count	ry?
ifter death with the Maryland ritems 23a or 28e-f show ther must be rediffed at Funeral Director	865 Lower Ferry	Road, #423		7-10	0861	8			United	Stat	es
items 2	11. Marital Status	12. Was Dacedant Armed Forces		13. Was Dece	dent of I	lispenic Or	lgin? (Spec	cify Yas or No- Rican, etc.)	14. Rec	e - America	
by by	3 ₺ Widowed 4 Divorced					Specify.		noan, orc.)	Specify	white, a	
led within 72 hours ygiene. Yer than "natural", It, its moulested by	15. Decedent's	Education	16e.	Decadent's Usu	el Occu	pation	et of workin	20	16b. Kind of B	siness/Ind	ustry
	(Specify only highest s Elementary/Secondery (0-12)	College (1-4or	5+)	(Give kind of wo life. DO NOT	se retire	d)	I OF WORKIN	'9	New Je	rsey	State
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tal Hy d othy	17. Fether's Neme (First, Middla, La	st)				18. Moth	er's Name	(First, Middle,	Meiden Sumen	ie)	
should be filed within and Mental Hygiene. marked other than marke event, to be To Be Compi	Paul Blumhardt					Ann	a Fis	scher			
	19a. Informent's Neme/Relationship	(Type, Print)	19b	Melling Addres	s (Stree	end Numb	er or Rura	Route Number	r, City or Town,	Stete, Zip	Code)
alth alth	Janet Doerstling	/ Daughter	HC	76 Coy	ote	Sprin	gs, I	Prescot	t Valle	y, AZ	86314
pemit. Pages 1 end 2 Department of Health important: if item 27 is any injury or other tra once.	20e. Method of Disposition		20b. Plece of	Disposition (Ne y, cremetory or	me of	ce) Augu	set 26	Dete 1008	20c. Location -	City or To	wn, Steta
Page ent c	1 ☐ Burial 2 ☑ Cramation 3 4 ☐ Donetion 5 ☐ Other (Spe		The state of the s	mery Cr		_			Bethesd	a Ma	rvland
ortar inju	21. Signature of Funeral Service Lice		Honego								eral Hom
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	23a Part I Errer the disease, or co shoot of heart alure. List on	mplications that cause ly one cause on each i	ine.	not antar tha mo	da oi dyi	rig, such as	cardiac of	r respiratory ar	rasi,		Approximete Intervel Between Onset end Deeth
Physician	W.										Onset end Deeth
/Medical Examiner	Immediate Ceuse (Final disease or condition	Myoca	ardial In	nfarctio	n						
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bend so de	Lupus Elythema	.0515									
requires een sign nould be								24a. Was	an autopsy med?	24b. We	ere eutopsy findings eilable prior to
sho sho								perio	illiou i	COL	mpletion of cause deeth?
the law require the sate has been signed as the same sate of the s								10	es 2 No		Yes 2□ No
certificata rector, pag		1				00 81					165 2010
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this ald district the state of	1 X Yes 2 No 27. Menner of Deeth	1 □ Inpat	ient 2 ER/Ou		UA				lence 6 XIOth		House
fing I	1 Neturel 5 ☐ Pending		njury M	28c. Inju	rk?]Yes 2[Lou. Describe	iow injury occur	100		
tend fleath for: the the	2 Accident investigation					1165 ZL		not Looption (cation (Street end Number or Rural Route Number,		
fraci ireci in by	4 Homicide determine	A Zee, Place of in	ijury - At home, fa tc. <i>(Specify)</i>	rm, street, facto	ry, offica		-	City or To		er or Hura	r Houte Number,
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n 24 hound no 24 h	(Check only 2 Medical Ex	Physician: To the best aminer: On the basis of									
	one)	end menner s		1							
	290. Signature and title of continet		///	F/ 25	c. Licen	se number			29d. Date signe	-	
12	Allen	4///	111	7	D	07099			AUGU	51	23 9
	30. Neme end eddress of person wh	o completed cause of	deeth (Item 23e)	(Type, Print)							10
	Francis C. Mayle)215 Feri		ad.	Reth	ehe	Marvila	nd 208	317	
State	31. Date filed (Month, Day, Year)		rer's Signeture	, ,			-bua,	IIII y I c	200	1	
State Registrar	AUG 2 6 199		vai to	1. 600	uks	/					
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Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Amend #4a & 23a, 9/1/98, BMW, Montg. Co. per physician Certificate of Death 1. Decedant's Neme (First, Middle, Last) 2. Deta of Death 3. Tima of Death Day Month Yaar **Physician** August 25, 1998 John Reich 3:30 AM /Medical 4e Fecility Neme (If not institution, giva street and number) 4b. City, Town, or Location of Daeth 4c. County of Death **Examiner** 9504 Watts Branch Way Drive Rockville Montgomery If Under 1 Year | if Under 24 Hrs. 5. Social Security Number 7. Aga (In vrs. last birthday) Birthplace (Stata or Foreign Country) 8. Deta of Birth (Month, Day, Year) Funeral Days 1₩ M 2□ F 109-18-7582 84 April 15,1914 New York Director Usual Residence of Decedant the Maryland 10c. City. Town or Location or 28a-f show 10e. State 10b. County 10d, inside City Limits Maryland Montgomery Rockville 1 ☐ Yas 2 No Directo 10e. Street and Number 10f. Zlp Coda 10g. Citizan of What Country? 0 8 with ma 23a 9504 Watts Branch Drive 20850 United States Funerai Indoe filed within 72 hours after deeth fental Hygiene. ked other than "natural", or itema 23 ic event, in a Medical Examiner must deeth Was Decedent of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Rece - American Indien, 12. Was Decedant Evar in U,S. Armed Forces? 11. Marital Status Black, Whita, atc. 1 XYas 2 No World If Yas, Giva 1 ☐ Never Married 2 ☑ Married Specify: White Baltimore, Maryland 21215-0020 1 ☐ Yas 21 No Specify: by 3 ☐ Widowed 4 ☐ Divorced Yaar or Datas: War II Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada complated) Collaga (1-4or 5+) 5+ Elamantary/Secondary (0-12) Attorney U.S. Government permit. Pages 1 and 2 should be file Department of Health end Mental Hy, Important: If item 27 is merked othe any Injury or other traumatic event, page. 18. Mothar's Nama (First, Middla, Maidan Surnama) 17. Fathar's Name (First, Middla, Last) Be Hyman Reich Rose Gelman Lo 19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a, Informant's Name/Ralationship (Type, Print) Marguerite Reich/ Wife 9504 Watts Branch Drive, Rockville, Maryland 20850 20b. Placa of Disposition (Nama of camatary, cramatory or other place) August 27,1998 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 【SCramation 3 ☐ Removal from Stata 4 Donation 5 Other (Specify) Montgomery Crematorium, Inc. Bethesda, Maryland of Funaral Sar 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ de Lio Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 M08689 hasa, or complications that caused tha death. Do not antar the mode of dying, such as cardiac or respiratory errast, ra. List only one cause on each line. Approximata intarvai Batwean Onsat end Daath **Physician** (Final /Medical Metastastatic liver disease Imm (F disaese or condition rasulting in daeth) -Liver Matastases One Month Examiner Dua to (or as e consequance of): Examine Primary unknown Abdominal Malignancy Unknown physician and the burief-transit the death certificate be executed Sequantially list conditions, if eny, laading to immadiata cause. Enter Underlying Causa (Diseasa or injury Due to (or as a consequence of): Box 68760, Physician/Medicai that initiated avants resulting in death) Last Dua to (or as e consequance of): for use as 60 signed by the e 23b. Did tobacco use contribute to the cause of death? Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. Division of Vital Records, P.O. 1 Tes 2k No 3 Probably 4 Unknown thet þ The law requires 24b. Wera eutopsy findings evailable prior to compation of cause been si Completed 24a. Was an autopsy of death? certificate has t 1 Yas 2 No 1 ☐ Yas 2 ☐ No Physician: director, 25. Was casa rafarred to medical axaminar? Be 26. Placa of Deeth (Check only one) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Nasidance 6 Other (Specify) 10 1 Yas 2 No this funeral 28a. Data of injury (Month, Day Year) 28d. Dascribe how injury occurred 27. Manner of Death 28c. injury at Work? 28b. Tima of Certification: After Attending 1 (X Natural 5 Panding investigation death. 1 ☐ Yas 2 ☐ No Director: 2 Accidant 6 Could not be determined 3 Suicida 28f. Location (Streat and Number or Rural Route Number, City or Town, State) 28a. Place of injury - At homa, farm, straat, factory, offica building, atc. (Specify) after 4 | Homicida 6

n 24 hou. The Funeral Direction edicai To the Hosp within 24 hos To the Fune completely fi 24+

> Sidney J. Cohen, M.D. 31. Data filad (Month, Day, Yaar) State AUG 26 Registra

29a, Certifier

(Check only one)

29b. Signature and title of certified

32. Registrer's Signature

30. Nama and addrass of person who complated cause of death (itam 23a) (Type, Print)

1998

121 Congressional Lane, #402, Rockville, Maryland 20852

1 🔀 Certifying Physician: To the best of my knowledge, death occurred et tha tima, data end piece, end dua to tha cause(s) and mannar as stated.

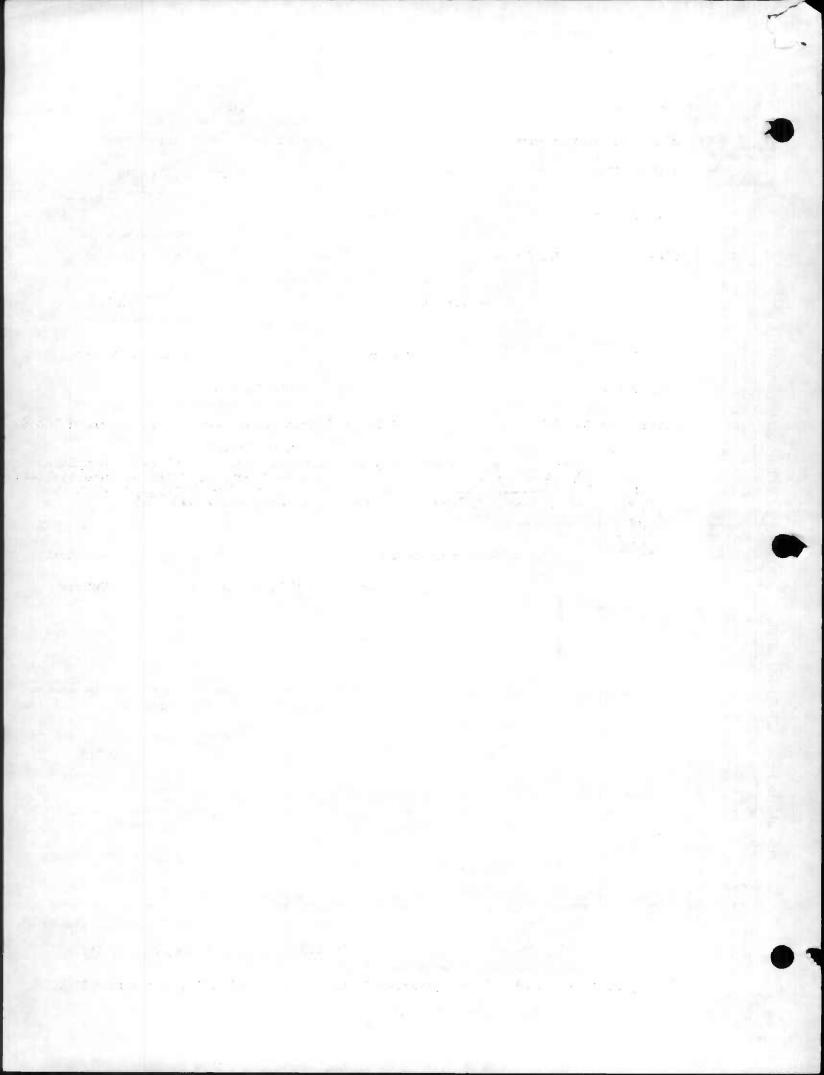
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, daath occurred at the time, date end place, and dua to the cause(s) and menner stated.

29c. Licansa number

D01193

29d. Data signed (Month, Day, Year)

August 25, 1998



Please Type or Print in Biack indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Leslie C. Reeley 18, 1998 5:40 AM August 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Wilson Health Care Center Gaithersburg Montgomery If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Dey, Year) 5. Social Sacurity Number 7. Aga (In yrs. lest birthdey) Birthplace (State or Foraign Country) 1⊠M 2□ F Months Yrs. 220-32-5517 100 November 8,1897 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ▼Yes 2 No Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 301 Russell Avenue 20877 United States 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Maritel Status 1 ☐ Yes 2 ☒ No If Yes, Giva Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ₩ Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Senior Clerk Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Nama (First, Middla, Last) Charles W. Reeley Mary Biggs 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 215 North Power Road, #333, Mesa, Arizona 85205 Marjorie J. Yates/Daughter 20b. Placa of Disposition (Nama of cemetery, crematory or other plece) August 21, 1998 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery Brentwood, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue, disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or raspiratory arrast, ailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ceuse (Finel disease or condition resulting In death) bronch. h Sequentially list conditions, if any, laading to immadiate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): Due to (or as a consequence of): 23b. Did tobacco was contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 1 NO 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. Stata

Directo

Funeral

by

Completed

Funeral

Director

with the Maryland

permit. Peges 1 end 2 should be filed within 72 hours efter deeth with the Marylen Depertment of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show way fujury or other treumstic event, the Moo call Examined must be notified at ence.

and I-transit The law requires that the deeth certificate be executed physician ar s the buriel-ti 80 use for signed by the e certificate hes b Physician/Medical Examiner

by

Completed

Be

P

Certification:

edical

John

31. Date filed (Month, Day, Year)

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certifics completely filled in by the funeral director, I

State Registrar

25. Was cese referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Death 28d. Describe how Injury occurred 28a. Date of injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 5 Pending Investigation 1 Natural 1 Yes 2 No 2 Accidant 6 Could not be determined 28f. Location (Straet end Number or Rural Routa Number, City or Town, Stete) 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicide 29a. Certifier (Check only one)

1 Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29b. Signature and titla of certifiar 29c. Licanse number 29d. Date signed (Month, Day, Year)

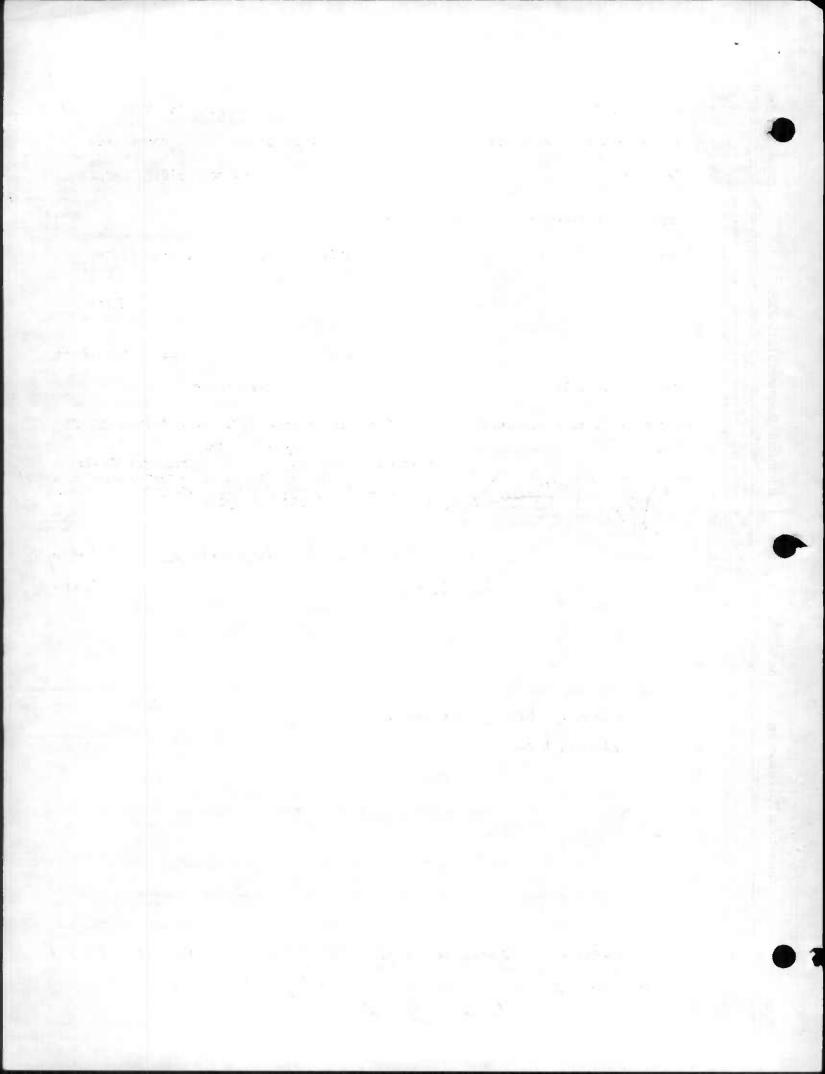
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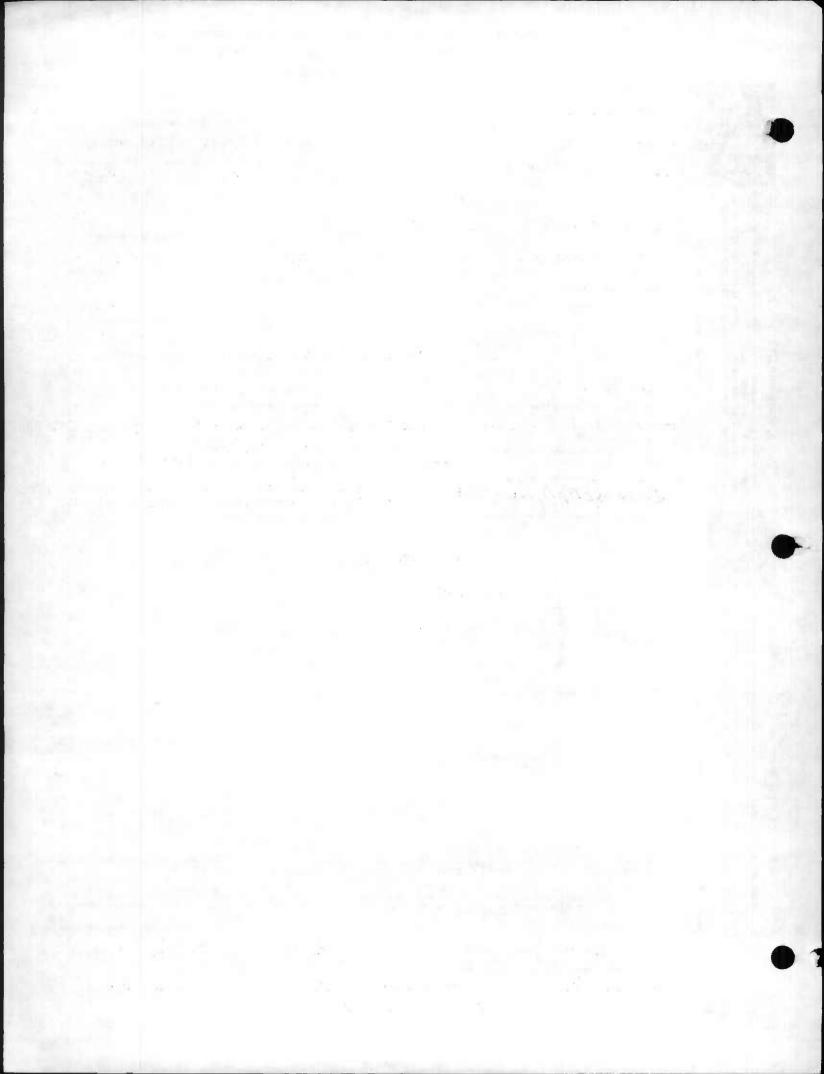
30. Neme and ad ss of person who completed ceuse of death (Item 23a) (Type, Print)

Rusa 32 Registrar's Signeture

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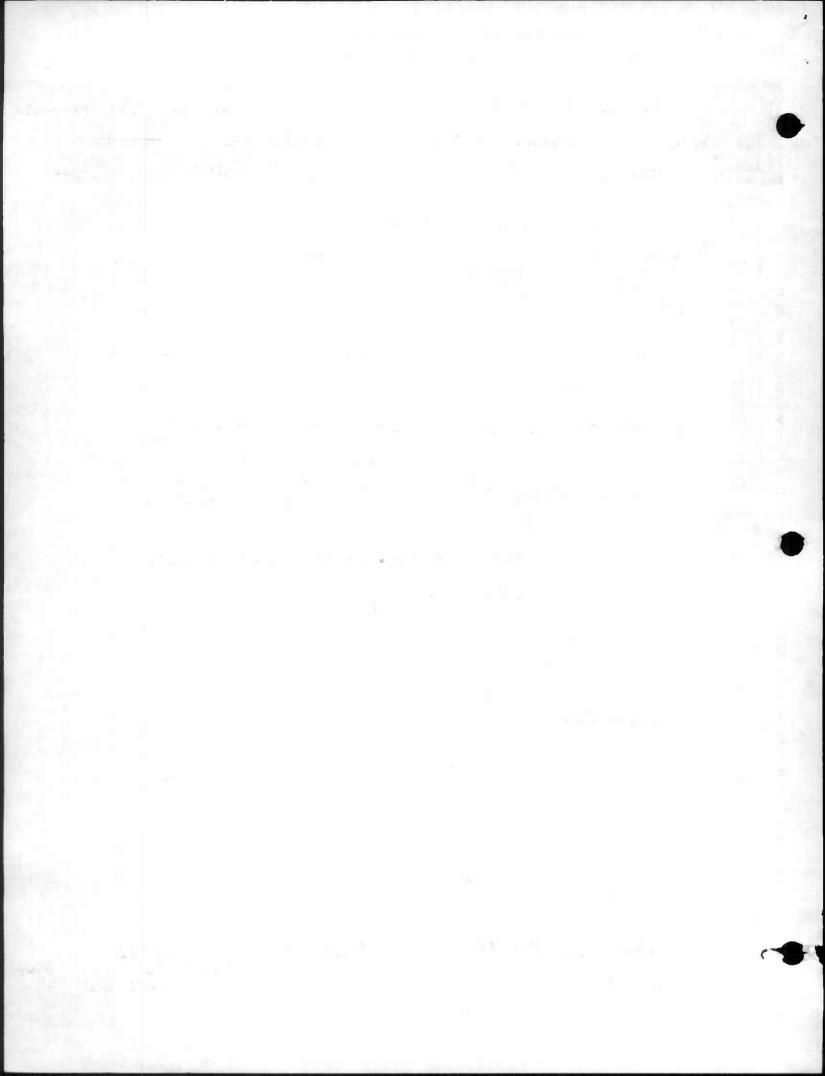


	4 Paradasiana des a adrici	f 41		Cer	tificate	of	Death	100		g. No.	6-0	7468	
sician	1. Decedent's Name (First, Middle,							2. Date Mont	h	Day	Yeer	3. Time of Deeth	
edical	Carol J. Reese 4a Facility Neme (If not institution, g		num <i>ber)</i>				b. City, Town, o	Augu r Location of		21, 199 4c. County		4:00 PM	
miner	Brighton Garden		,				North E				gome	rv	
ral		. Sex	7. Age (In yrs.	last birthday)	If Under 1 Months	Year Days	If Under 24 Hr Hours Mi	8. Dete				lace (State or Foreitry)	ign
tor	276-12-1400	1□ M 2ሺ F	77	Yrs.	Michigan	Lietys	risans min	July	22	, 1921	Oh		
ral Director	Usual Residence of Decedent 10e. State 10b. County		10c, Cit	ty, Town or Loc	ation						1	Dd. Inside City Limi	its
ò		m o 2011										1 X Yes 2 □ N	
Directo	Maryland Montgo 10e. Street and Number	шегу	, r	Rockvil	10f. Zip C	Code			10	og. Citizen of W	hat Coun	try?	
	11805 Stonewood	Lane			20	0851	2-0337			United	Sta	tee	
Funeral	11. Marital Status	12. Was De	ecedent Ever in U Forces?	,S. 13. W			lispanic Origin? (en, Mexican, Pue	(Specify Yes	or No-	14. Race	- Americ	an Indian,	
2	1 Never Married 2 Married	1 Ye	s 2 XNo		Yes 2		Specify:	orto riloari, etc	Specify:			HG.	
d by	3 Widowed 4 Divorced	Yeer or									Whi		
Completed	15. Decedent's (Specify only highest of		d)	16a. Deced	ent's Usuel	Occup done	ation du <i>ring</i> most of w d)	rorking	16b. Kind of Business/Inc District of				
dimo	Elementary/Secondary (0-12)	College	(1-4or 5+) 5+							Governm		Columbia	a
	17. Father's Neme (First, Middle, La	st)	18. Mol							faiden Sumem			
17. Fathe	Leo Jacobs						Ruth	M. Mi	tte	nthal			
-	19e. Informant's Name/Reletionship	(Type, Print)		19b. Mailin	Address ((Street	end Number or I				Stete, Zip	Code)	
Leo 19e. Informant Howard 20a. Method of	Howard C. Reese	/ husba	nd	11805	Stone	ewoo	od Lane,	Rocky	7i11	e, Mary	land	20852-0	337
	20a. Method of Disposition 1 Deliver Burial 2 Degree Street 2 Degree 3	□ Removel fro	20b. f	Dieno of Dienos	ition /Alomo	0 01	August 2	Date		20c. Location -	City or To	wn, State	
	4 Donation 5 Other (Spe						orium,			ethesda	, Ma	ryland	
9008	21. Signature of Funeral Service Lie	muller	Lawren	Re Re	obert A	. Pu							
	23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that	at caused the deat	th. Do not ente	r the mode	of dyin	ng, such as cardi	ac or respirat	ory arre	est,		Approximate Interval Between	
n	In the Court of th										i	Onset and Death	
r	Immediate Ceuse (Final disease or condition resulting in death)	a. E	nd Stage	Demen	tia								
5				or as a consequ	uence of):								
Examiner		■ bD	ehydrati	on or as e consequ	ionno of						i		-
Exa	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying				Jenice Or).						1		
dical	ceuse. Enter Underlying Cause (Disease or injury that initiated events	cM	alnutrit Due to (d	ilon or es e consequ	ience of):								
Med	resulting in death) Last										1		
any		d									1		
Physician/Me	Part II. Other eignificant conditions	contributing to	death but not res	sulting in the un	derlying cau	use giv	en in Pert I.	23b	Did to	bacco use con	tribute to	the cause of deal	th?
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d by								240	Mes	n autopsy	24h W	ere autopsy finding	16
eted								240.	perform		av	mpletion of ceuse	
Complet									**			death?	
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o Be	25. Wes case referred to medicel examiner?	Hospital:	Diagratical OF) FD/O	a□ po4	Oth	26. Plece of D				(Casaid		
-	1 ☐ Yes 2 XNo 27. Menner of Death	28a. Da	te of Injury	28b. Time of		1	4 KM Nursing	1	_	nce 6 Other		//	
at o	28a. Date of Injury 1 Netural 5 Pending (Month, Dey Year) 28b. Time of Injury Work? 1 Netural 5 Pending investigation 28b. Time of Injury Work? 1 Yes 2 No												
ertifica	27. Menner of Death 1 Netural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury M 28b. Time of Injury at Work? 1 Yes 2 No 28d. Describe how Injury occurred 28d. Describe							i Route Number,					
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Medicai Certifi							e number		2	9d. Date signed	(Month,	Dey, Year)	
	1 alberth	100	mi			DO	1100			A	2/	1.000	
	30. Name end eddress of person wh			m 23e) /Tvne f	Print)	טט	31282		4	August	24,	1998	
	The same of the sa												
1	Albert Lee, M.D	. 8218	Wiscone	in ATTAT	1110 1	#10º	, Bethe	sdo N	(art	land 20	21/		



State of Maryland / Department of Health and Mental Hygiene Amended Item 4c, per Phy. 8/26/98, Carroll County, wjl Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3 Time of Death **Physician** Month Vos Redman Linda 12:40a m 13 2 98 /Medical 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Daath Examiner Johns Hoptino Bayview. Baltimore 4 6 Hours Min. 8. Data of Birth AMonth Dest 7, 1950 5. Social Security Number 6 Sax 7. Aga (In yrs. last birthdey) Birthplaca (Stata or Foreign Country) **Funeral** 1□M 21 F 48 Yrs. Director 217-54-0305 Maryland Usual Rasidance of Dacedant filed within 72 hours efter death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner numbe notified at 1 √ Yas 2 No Director Baltimore City Baltimore 10e. Street end Number 10f. Zip Coda 10g. Citizen of What Country? ò Items 23a 3823 8th Street Completed by Funeral 21225 U.S.A. 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yes 2 ☒ No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, etc. 11. Marital Status 1 Nevar Married 2 Married 21215-0020 ŏ 1 ☐ Yas 2 No Specify: Specify: White 3 Widowed 4 □ Divorced "natural", 16a. Dacedant's Usual Occupetion (Give kind of work dona during most of working life. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grade completed) 16b. Kind of Business/Industry tal Hygiene. Elamentery/Secondery (0-12) College (1-4or 5+) 9 Homemaker Domestic Baltimore, Maryland 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Name (First, Middla, Maidan Sumama) Pages 1 end 2 should be fill ment of Health end Mental Hant: If item 27 is marked oth jury or other traumatic even Be William Ward Mary Ward 19a. Informant's Name/Ralationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 3823 8th Street, Baltimore, MD 21225 Ms. Wendy Markell (Daughter) 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, crematory or other place) Data 20c. Location - City or Town, Stata 1 ☐ Buriel 2 X Cramation 3 ☐ Removel from Stata permit. Page Depertment of important: If any injury or once. 8/24/98 Hampstead, MD Carroll Cremation Serv. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funaral Sarvice Licensaa 22. Nama and Addrass of Facility
HAIGHT FUNERAL HOME & CHAPEL (Box 195) Brean X. Was Sykesville, MD 21784 (410)-795-1400 23a. Part1. Entar tha disaasa, or complications that ceusad tha daath. Do not antar the mode of dying, such as cardiac or raspiratory arrest, shock, or heart feilura. List only one cause on each line. Approximate intarval Batwaan Onsat and Deeth **Physician** /Medical Immediata Causa (Final Bladden CA = mets to lung to disease or condition rasulting in daath) Examiner Examiner Dalumonia The law requires that the death certificete be executed Sequantially list conditions, if any, laading to immediata cause. Enter Undarfying Causa (Disaase or Injury that initieted events resulting in death) Last Dua to (or as a consequence of): pue stending physician e Box 68760, Physician/Medical Due to (or es a consequance of) the a Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. ate hes been signed by page 2 should be detec 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown preumoni by 24b. Ware autopsy findings eveilable prior to completion of causa of daath? Completed 24e. Was en eutopsy certificate hes 1 ☐ Yes 2 No 1 ☐ Yas 2 ☐ No Division of Vital al or Attanding Physician: The sefter death.

It Director: After this certificate of in by the funeral director, pt Be 25. Was casa rafarrad to medical 26. Placa of Daath (Check only ona) Othar: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 2 1 Yas 2 No 1 ☑ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Certification: 27. Manner of Death Date of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how Injury occurred 28c. Injury at Work? 1 Natural 5 Pending invastigation 1 Tas 2 No 2 Accident 6 Could not ba datamined 28a. Place of Injury - At home, farm, straat, factory, office building, atc. (Spacify) 3 Sulcide 28f. Location (Street end Number or Rural Routa Numbar, City or Town, Steta) filled in by 4 Homlcide Hospital 24 hours 24 hours To the Hospi within 24 hou To the Funer completely fil 29a. Cartifian 🔁 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and manner as steted. Medical 2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred et the time, date and place, and due to the causa(s) end manner stated. 29b. Signature and titla of certifiar 29c. Licansa number 29d. Data signed (Month, Day, Year) 140 30. Nama and address of parson who completed causa of daath (Itam 23a) (Type, Print) Hospita SoonBok Woo MD 4940 Eastern Av Bayview 31. Data filed (Month, Dey, Yeer) 32. Ragistrar's Signatura State Registrar AUG 2 6 1998



State of Maryland / Department of Health and Mental Hygiene

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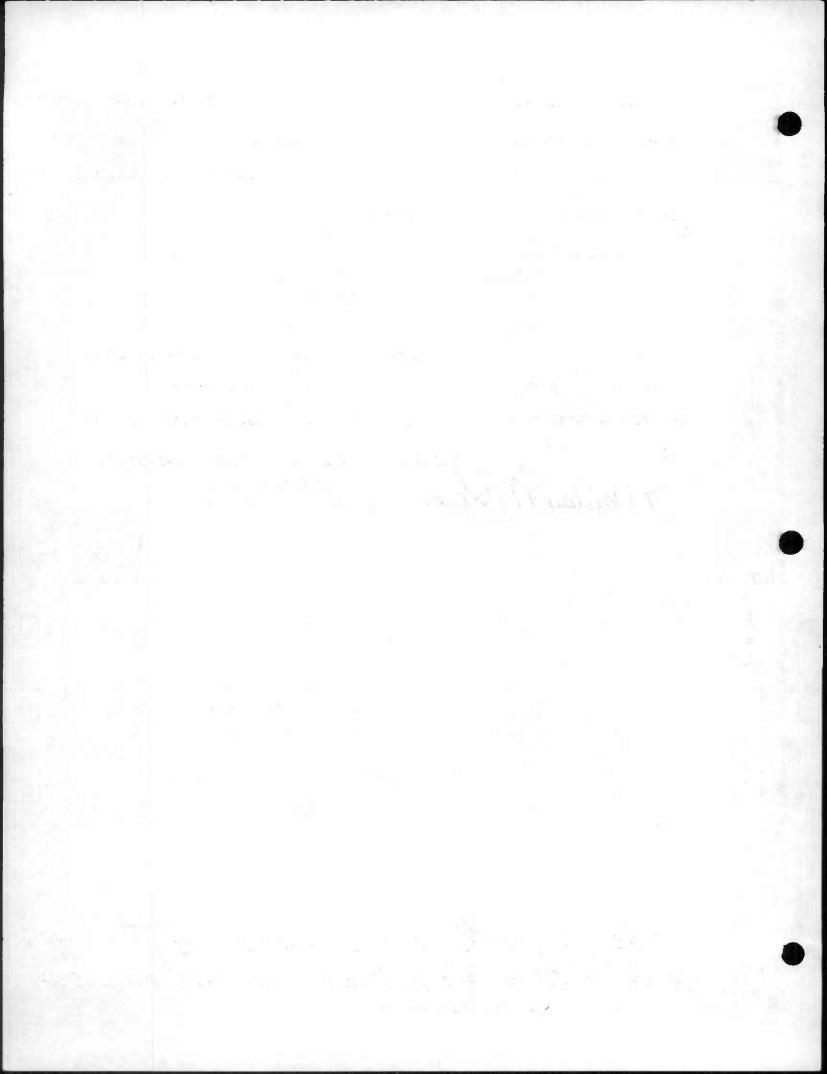
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	Physic	ian	1. Decedent's Name (First, Middle	1	7					2. Date of Dea	ath Day	Year	3. Time of Death
J.	/Medi		trank	a	Ras	e				08	27	98	12:20p.m.
J	Exami	ner	4a. Facility Name (If not institution	give street and number)					cation of Death	4c. Coun	ty of Death	
			Corsica Hills 5. Social Security Number	6. Sex 7. A	// /	4 6 5 4 5 - 1	If Under 1 Year	Centi			Que	en Anr	
ů.	Funeral Director		579-28-2120 Usual Residence of Decedent	XOM 2□F	ge (In yrs. las	Yrs.	Hunder 1 Year Hunder 24 Hrs. 8. Date of Birth (Months Days Hours Min. 9. Birthplace (St. Country) 1910					place (State or Foreign ontry) adford, MA	
	how		10a. State 10b. County		10c. City, 7	Town or L	ocation				10d. Inside City Limits		
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	er a	Dire	10e. Street and Number				10f. Zip Code				10g. Citizen of	What Coul	ntry?
	ath w		631 High Street				21620				U.S.A.		
21215-0020	filed within 72 hours efter death with the Maryland hygiene. ther than 'natural', or items 23a or 28a-f show ont, the Medical Examinar must be notified at	by Funeral	11. Maritel Status 1 □ Never Married 2 □ Merrie 3XXVidowed 4 □ Divorced	12. Wes Decedent Armed Forces d 1 □ Yes 2 ₹ If Yes, Give Year or Dates:	?	13.	Was Decedent of If Yes, specify Cut 1 ☐ Yes 2X No		gin? (Spe , Puerto F	cify Yes or No- Ricen, etc.)	14. Ra Bla Speci	ice - Americ ack, White, ify: Wh	
5-0	72 h natu	Completed	15. Decedent' (Specify only highes)	Education orade completed)	1	16a. Dece	edent's Usual Occu	pation	of workin	ng.	16b. Kind of I	of Business/Industry	
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	be filed within tal Hygiene.	ပိ	12 17. Father's Name (First, Middle, L			Rea	al Estate			(First, Middle,			e/Self emplo
Maryland	od is o	Be C	Frank Goulet Ros	· ·							Maiden Suma	me)	
7	2 should be and Mental is marked o	2	19a. Informant's Name/Relationsh			19h Mali	Inn Aridress (Stree		Sylv	/ 1.a / Route Number, City or Town, State, Zip Code)			
	ore, no les 1 end of Health filtem 27 or other tr		Gerald Rose/Son	p (1)p0,7 tm,			High Stre				Maryla		
re,			20a. Method of Disposition		20b. Plac		osition (Name of matory or other pla		rebec	Date	20c. Location		
mo			1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		,				101161	31 10	008/Pma	ntreas	d , Maryland
alti	교원 분들		21. Signature of Funerel Service L		~		2. Name end Addr			JI, 1	JOINE.	IILWOO	1, ratylati
ä	Deper Impo		* Kuif V	2/04/1	(Fe	llows, Hel O Speer Ro	fenbein	& New	nam Fune	ral Home	P.A.	
	_		23a. Part1. Enter the disease, or o shock, or heart failure. List of	omplications that couse	d the deeth.	L.5 Do not en	U Speer Ro	ing, such as	sterto cerdiac or	wn, Mary	Land 21 rest.	620	Approximate
ł	Physician		shock, or heart failure. List o	nly one cause on each I	ine.								Interval Between Onset and Death
	/Medicai		Immediate Cause (Final disease or condition	Z	esni	rat	ory fo	allava	p				1 day
	Examiner		resulting in deeth)	a	Due to (or as		,	10 (900					
					Pneu	mo	snia						4 days
	eath certificate be executed attending physician and for use as the buriel-transit	Examiner	Sequentially list conditions, Due to (or as a consequence of):									1	
68760,	be ex	a E	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of):										
387	phys the	edicai	that intitated events resulting in death) Last Due to (or es e consequence of):										
×	ding ding se as	2		d									
Box	atten for u	ciar										1	
P.O.	requires thet the death certificate be executed seen signed by the attending physician and thould be detached for use as the bunel-transit	Physician/	Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. COPD: ASCVD; CVA; Reuiplegia; Ameru							23b. Did tobacco use contribute to the cause of			
	thet deta	by Pt	COPD' ASCV	Dz; CVA	', (R)He	emil	legia i	Huew	uig . 1 Yes 2 No 3 Probably				bably Dunknown
rds,	quires n sign			J .			•			24a. Was	en eutopsy	24b. W	ere autopsy findings
CO	law require las been sign 2 Should b	iet	P.V.Dz.; Dei	neulla						perfor	med?	CO	ailable prior to mpletion of cause death?
of Vital Record	0 - 0	Completed								1 U Y	es 248 No		☐Yes 2☐ No
ā	ician: The	BeC	25. Was case referred to medice!					26. Piece	of Death	(Check only or			3163 20.40
>		ToE	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpati	ent 2 ER	/Outpatie	nt 3 DOA Ot	hor.		e 5 Resid		her (Specif	v)
0 4	ig Physter this neral d		27. Manner of Death 120 Natural 5 ☐ Pending	28a. Dete of Inju	lry Year) 28	b. Time o	of 28c. Inju	-		8d. Describe h			
Division	Attending or deeth.	Certification:	2 Accident Investiga	tion		,,		Yes 2□1	No				
Ĭ Ž	or Att	THE STATE OF	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ed 286. Place of in	jury - At home c. (Specify)	, farm, st	reet, factory, office		2	8f. Location (S City or Tow		ber or Rura	al Route Number,
٥	rai Dellied ii												
	To the Hospital or Attanding F within 24 hours after deeth. To the Funeral Director: After completely filled in by the funer	Medical	one) 2 Medical E	Phyalcian: To the best taminer: On the basis o and menner st	f examination	dge, deat and/or in	h occurred at the ti vestigation, in my	me, date and opinion, deet	d place, ar h occurre	nd due to the d d at the time, d	euse(s) and m late and place	anner as s , and due to	(ated.) the cause(s)
	To with	5	29b. Signature end title of certifier	Dod	LS		29c. Licen	se number	6	2	9d. Date sign	ed (Month,	Day, Year)
			30. Name and address of person w		death (Item 23	1077	S au	162	0				
	Sta	te	31. Date filed (Month, Day, Year)	32. Regist	ar's Signature	9	4. Spar			-			
	Registr	ar	AUG 2	3 1998	ener	1	. spa	Ks					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Dev Aug 16, 1998 4b. City, Town, or Location of Death /Medical Charles Irwin Sager 5:08 PM Examiner Cumberland Nursing Home Cumberland
If Under 24 Hrs. 8. D
S Hours Min. (A Allegany If Under 1 Year Months Deys 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthdey) Fulleral 8. Date of Birth (Month, Dey, Year) 9. Birthpleca (State or Foreign Country) 1905 Months 1₩ 2□ F Yrs **Director** 89 508-22-6900 Usual Residence of Deceden Nov. 15, 1908 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits notified at Maryland Allegany 1 □ Yes 2 □ No Director Frostburg the 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? ò itams 23a Funeral 70 E. College 12. Was Decedent Ever in U,S. Armed Forces? 21532 72 hours efter death USA 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Reca - American Indien, Bleck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Yeer or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 natural', or 1 Yes 2 No Specify: Specify: White by 3 Widowed 4 Divorced Completed traumatic avant, the Medical 15. Decadent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Haaith and Mantal Hygiena. ant: If Item 27 is marked other than "rury or other traumatic avant, The Man Elementary/Secondary (0-12) College (1-4or 5+) 8 Professor College System 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be 2 Charles Sager Alpha (Duflinger) 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 92084 Gene Charles Sager 1160 Cypress Drive , Vista, CA 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete Date permit. Pages Department of Important: If it any injury or c 1 XBurial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Hillcrest Memorial P. 8/18/ Cumberland, MD 21. Signature of Funday Service Licenses 22. Name and Address of Fecility Kight Funeral Home Man 309-311 Decatur St., Cumberland, MD 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause of each line. **Physician** . CHRONIC Immediete Ceuse (Final diseese or condition resulting In death) /Medical OBSTRUCTIVE PULMONARY nn Know Examiner DISEASE Due to (or es e consequence of) Physician/Medical Examiner ician end buriel-transit The law requires thet the death certificeta be axecuted Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting In deeth) Lest Due to (or es e consequence of) Box 68760, physician s the burie Due to (or as e consequence of): for use signed by the ed P.O. Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. by 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed 24a. Wes en eutopsy paga 2 certificeta 1 Tyes 2 No 1 Yes 2 No or Attending Physician: 25. Wes case referred to medical exeminer? Be 26. Piece of Deeth (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No this funeral 27. Manner of Deeth 28a. Date of Injury (Month, Dey Yeer) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending Investigation 1 Neturel death. 1 Yes 2 No after death Director: 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) á 4 Homicide Hospital 24 hours a 29e. Certifier 🗠 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the ceuse(s) and manner as stated. To the Hosp within 24 hou To the Fune completaly fi Medical (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29b. Signeture and title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) Tonon MD AUG 17,98 D23371 10 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) 31. Determent Month, Day, Your aman, M. Reylster's Signature 1, Cumberland, MD 21502 Geneva J. Sports Registrar **DHMH 16 Rev 6/95**

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** Rose Violet Skidmore August Pay, 12:05 AM /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FROSTBURG VILLAGE NURSING HOME FROSTBURG ALLEGANY 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) 7. Age (In yrs. last birthday) **Funeral** Birthplace (Stete or Foreign Country) Months Days 1 □ M 2 □XF Yrs Director 212 01 9742 84 DEC 10 1913 MARYLAND Usual Residence of Decadent death with the Manyland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f shortman MARYLAND ALLEGANY Director FROSTBURG 1 ☐ Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of Whet Country? 11207 SUGAR ROW ROAD, NW by Funeral 21532 U.S. 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☐ YNO If Yes, Give Year or Dates: items! Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, traumatic event, the Medical Examiner Black. White, etc. filed within 72 hours effer 1 Never Married 2 Married 21215-0020 6 1 ☐ Yes ZENO Specify: 3 √Widowed 4 □ Divorced WHITE "netural". Completed 16a. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traument. Elementery/Secondery (0-12) College (1-4or 5+) 10 FLOOR SUPERVISOR SEWING FACTORY altimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) 8 GEORGE H. DONIUS ROSE VIOLET PORTER 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) BRADFORD MARTIN/NEPHEW 11207 SUGAR ROW ROAD, NW, FROSTBURG, MD 21532 20b. Placa of Disposition (Neme of cemetery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 D Buriai 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 □ Other (Specify) FROSTBURG MEMORIAL PARK | 8/13/98 FROSTBURG, MD 22. Name and Address of Facility
SOWERS FUNERAL HOME, P.A. 21. Signature of Funeral Servica Licanse Quess 60 W. MAIN ST., FROSTBURG, MD 21532 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting In death) /Medical Examiner Examiner INFIARCTION The law requires that the death certificete be executed the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last pue P.O. Box 68760, ettending physician ENOUS Physician/Medical Due to (or as a consequence of) theen signed by the e Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records. þ Completed 24a. Wes an autopsy performed? 24b. Were eutopsy findings available prior to completion of cause of death? 4LZ-HEIMERS DISEASE 1 ☐ Yes 2 ₺ No 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) 10 Other: 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28c. Injury at Work? 28a. Dete of Injury (Month, Dey Year) Certification: 28b. Time of 28d. Describe how Injury occurred Attending 1 Natural 5 Pending investigation death 1 Yes 2 No after death 6 Could not be 3 Sulcide 28e. Piaca of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) à 4 Thomicide within 24 hours To the Funeral I Certifying Physician: To the best of my knowledge, death occurred et the time, date and placa, and due to the cause(s) end menner es steted.

Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, death occurred et the time, date and placa, and due to the cause(s) end manner stated. Medical 29a. Certifie 84 29b. Signature and title of certifie 29c, License number 29d. Date signed (Month, Day, Yeer) State egistrer's Signature Registrar

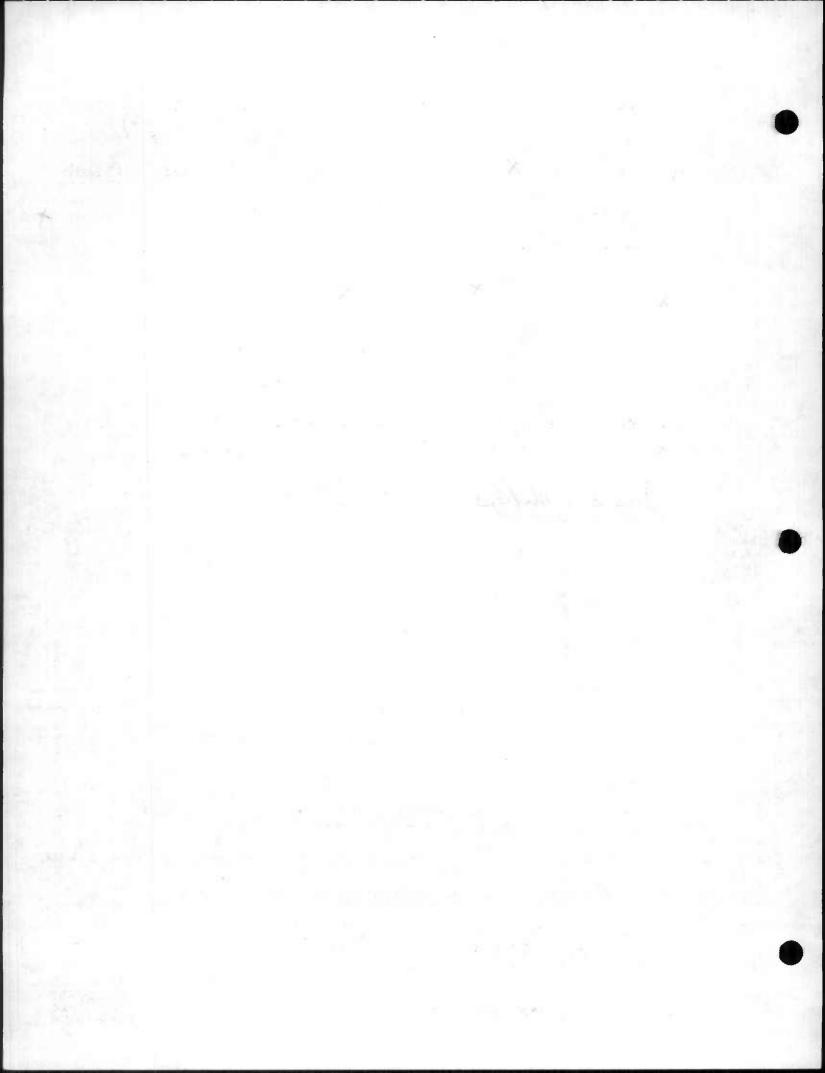


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** August 11, 1:00 P.M. Smith Flora /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Lonaconing Egle Nursing Home **Allegany** 5. Social Security Number If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) May 26, 1907 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign **Funeral** 1□M 2**X**F Mary Land Yes. Director 214-05-6670 Usual Residenca of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Exerginal must be included as Maryland Allegany Lonaconing 1 ☐ Yes 22 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16001 Bucks Hill Road 21539 USA death Funeral 11 Marital Status 12. Was Decadent Ever in U,S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married 1 Yes 2 Oo If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 White 1□ Yes 2 No þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mentel Hygiene Important: if item 27 la marked other than any Injury or other traumatic event, the Maginds. Elementary/Secondery (0-12) College (1-4or 5+) Home Homemaker 12 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hugh Rankin Nellie Jones 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nellie A. Woods-Daughter 21118 Circlewood Dr. S.W., Lonaconing, Md. 21539 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete Aug. 14, 1 Burlal 2 □ Cremetion 3 □ Removel from State Laurel Hill Cemetery Moscow Mills, Md. 4 ☐ Donation 5 ☐ Other (Specify) 1998 21. Signature of Funeral Service Licansee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or result, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Fina M. Muocardia disease or condition resulting in death) **Examiner** Examiner Hibillation 4 years The law requires that the deeth certificate be executed physician end sthe buriel-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or es e consequenca of) Records, P.O. Box 68760, years Physician/Medical ettending I Generalized Centenosclerosi 10 years ned by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown uctive Be Completed by sign After this certificate has been sifuneral director, page 2 should I 24e. Was an autopsy performed? 24b. Were autopsy findings eveilable prior to completion of ceuse of deeth? 1 Yes 1 ☐ Yes 2 ☐ No tai or Attending Physician: Tres effer death.

al Director: After this certificate led in by the funeral director, pe Division of Vital 25. Was case referred to medical examiner?
1 ☐ Yes 250 No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpetient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital of within 24 hours of To the Funeral D completely filled i 29a. Certifier TE Certifying Phyelclan: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. Medical (Check only one) 29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Day, Year) T12,1998 Ikc D07004 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) S? JACKSON ST. L.R. MILES, JR. M.D. LONACONING, MD 21539 32. Registrer's Signature 31. Dete filed (Month, Day, Year) State ALG 13 Registrar



			State of Maryl	•	artment of F <i>tificate of</i>			jiene 9	8 2	7474
	Physician /Medical	Decedant's Nama (First, Middla, Las	ETHEL	М.	SHA	ARON	2. Data of Das Month AUGUST	Day	Yaar	3. Time of Death 2:50 PM
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	show	10a. Stata 10b. County	100	. City, Town or Lo					10	d. Insida City Limits 1√□ Yas 2 □ No
	the M 28a-f porting	MD Allegany 10e. Street and Number		Cumber.	10f. Zip Coda			log. Citizen of W	What Count	41
	With With	134 East Elder St	reet		21502			USA		,,
020	ould be filed within 72 hours efter death with the Manyland Mental Hygiene. Mental Hygiene. Rickd other than "natural", or items 23a or 28a-f show attic event, the Medical Evansiner main be notified at To Be Completed by Funeral Director	11. Marital Stetus X Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever Armed Forcas? 1 ☐ Yas 【☐ No If Yas, Giva Yaar or Datas:			Hispenic Origin? (Sp an, Maxican, Puarto	ecify Yes or No- Rican, etc.)	city Yes or No- lican, etc.) 14. Raca - American Indi Black, Whita, atc. Specify: White		
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Maryland	t and 2 sh Health and tem 27 is m other traum	17. Father's Nama (First, Middle, Last) Charles Sharon	2751			18. Mother's Name Emma (Ro		dle, Meiden Sumama)		
ary		19a. Informent's Name/Relationship (7	Type, Print)	19b. Mailin	ng Addrass (Streat	and Number or Run	al Routa Numba	r, City or Town,	Stete, Zip (Code)
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altimore,		20a. Method of Disposition Y ■ Burial 2 □ Cramation 3 □ 4 □ Donation 5 □ Othar (Spacify	Ramoval from Stata		sition (Nama of netory or other pla orial Ce		Data 08/10	20c. Location - Cumber 1		
Balt	permit. Pages Department of Important: If It any Injury or otics.	21. Signature of Futeral Service Licen	Marcel	22	Name end Addre Scarpell Cumberla	i Funeral	Home,	P.A.		
į	Physician	23a. Part1. Enter the disease, or companions shock, or heart feilure. List of	tions that caus I that cause on each I e.	death. Do not ant	ar tha mode of dyi	ng, such es cardiac	or raspiratory er	rast,		Approximata Intarval Batwaan Onset end Daath
	/Medical Examiner	Immadiata Causa (Final diseasa or condition rasulting in daath)	α	to (or as a consag					0	ne Year
8760,	cete be executed physician and s the burial-transit	Saquentially list conditions, if eny, leading to immediate cause. Enter Underlying Course (Disease or injury that initiated events Dua to (or as a consequence of): Dua to (or as a consequence of):								
Box 687	requires that the death certificate be executed seen signed by the attending physician and hould be detached for use as the burial-transit eted by Physician/Medical Examin	that Initiated avants resulting in death) Last	Dua t	o (or as a conseq	uenca of):				1	
. E	a deat he att hed fo	Part II. Other algnificent conditions co	ontributing to death but not	rasulting in tha u	nderlying ceuse gi	ven in Part I.	23b. Did tobecco use contribute to the cause of deeth?			
s, P.O	es that the death certification of the attending to be detached for use estable by Physician/Me					1/2	res 2□ No	3 Prob	ably 4 Unknown	
Records,	The faw require cate has been si page 2 should I					24a. Was a	an autopsy med?	646	ra autopsy findings ilable prior to ipletion of causa aath?	
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≠	ding F th. After funer	27. Manner of Death 1 Natural 5 ☐ Panding invastigation	(Month, Day Yea	28b. Time of Injury	Wo	rk?]Yas 2 □ No	200. Dascribe II	low injury occurr	60	
Division of	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com	2 ☐ Accident invastigation 3 ☐ Suicida 6 ☐ Could not be 4 ☐ Homicide datarminad		At homa, farm, str pecify)			28f. Location (S City or Tow		er or Rure/	Route Number,
	thin 24 hours thin 24 hours the Funeral mpletely filler Medical C		ysicien: To the best of my liner: On the basis of axar end manner stated.							
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	State Registrar	31. Date filed (Month, Day, Year) AUG 1 1		program Brok	Suit					

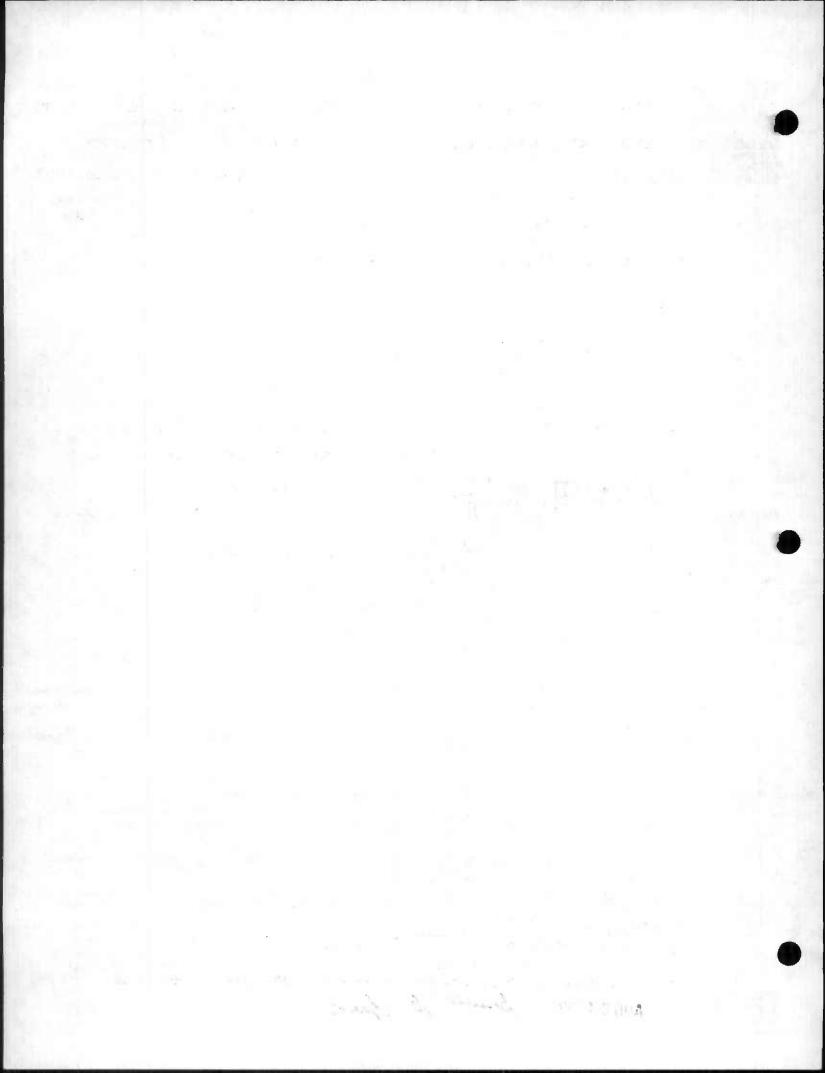
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State of Maryland / Department of Health and Mental Hygiene 3 274.75

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Physicia /Medic			AGNES	SCHMIT	T	Month AUGUST	21 1	998 1	:20 PM				
	/Medi Examii		4a. Fecility Neme (If not institution, g	JOSEPHINE iva street and number)			4b. City, Town, or L		4c. County				
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	Funeral			Sax 7. Ag 1 ☐ M 2 ☐ F	a (In yrs. lest birthday)	Months Days	If Undar 24 Hrs. Hours Min.	8. Dete of Birth (Month, Day,	Year)	9. Birthplaca (Country)	State or Forei		
	Director		213-18-3666 Usuel Residance of Decedent	X.	84 Yrs.			April 26,	1914	Baltimore	e, Maryla		
	/land		10a. State 10b. County		10c. City, Town or Le	ocation				10d. In	side City Limit		
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DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

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death. ctor: After y the fune fication	1 Natural 5 Pending 2 Accident investigati 3 Suicide 6 Could not datarmina	(Month, Day Year) ion be 28e. Place of Injury - At h	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number)				
within 24 hours after To the Funeral Dire completely filled in the		building, etc. (Special policy) Physician: To the best of my known aminer: On the basis of examiner.	owledge, death occurred	d at the time, date and place	e, and dua to the ca	use(s) and mannar a	is stated.	
Med Med		and mannar statad.						
Toron N		und m		b. License number b 40370		8/25/98		
15	30. Name and address of person wh	o completed cause of death (Iter	m 23a) (Type, Print)					

y Unit 3 Hug

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Time of Deeth Month Physiclan Samuel 1 Aug. 25, 1998 03:50am /Medical 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Silver Spring Holy Cross Hospital Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Undar 24 Hrs. 9. Birthplace (State or Foreign Country)
New York 8. Date of Birth (Month, Dev. 1**⊠** M 2□ F 90 Months Days Hours Yrs. Nov 23, 082-07-1605 1907 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits MD Funeral Director Montgomery Silver Spring 1 ☐ Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 415 Silver Spring Ave #505 20910 USA Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14 Raca - American Indian Black, White, etc. Yes 2 No If Yes, Give 1 ☐ Never Married 2 ☐ Married Specify: White 1 Ves 2 No Specify þ 3 X Widowed 4 ☐ Divorcad Year or Dates: WW TT Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Certified Public Accountant Accounting 17. Father's Name (First, Middla, Lest) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Isidore Sherman Sarah (unknown) 20 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Numbar, City or Town, State, Zip Code) Gail Sherman (Daughter) 18671 Sandpipier Lane Gaithersburg, MD 20879 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Crametion 3 Demoval from Stata 4 Donetion 5 Qther (Specify) King David Memorial Gardens8/27/98 Falls Church, VA sture of Funeral Sa 21. Sig rvice 22. Name and Address of Facility Danzansky Goldberg Memorial Chapels, Inc 1170 Rockville Pike Rockville,MD 20852 23a. Part1 to the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, he art failure. List only one cause on each line. Approximate Interval Between Onsat and Death Acute Renal Failure 1 week disease of condition Due to (or as a consequence of): Chronic Renal Disease Indefinite Examir Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of): Nephrosclenosis Indefinite Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Coronary Artery Disease by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Was an autopsy Generalized Arteriosclenosis performed? 2 No 1 Yes 1 Yas 2 No Be 25. Was casa referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Othar (Spacify) 1 Yes 2 No To 27. Manner of Death Date of Injury (Month, Dey Year) 28b. Time of 28d. Dascribe how injury occurred Certification: 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accidant 3 Suicide 6 Could not be determined 28f. Location (Street and Numbar or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide edical 29a, Certifier Certifying Phyaicien: To the best of my knowledge, death occurred at the time, date end plece, end due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D09215 Aug. 25, 1998 end address of person who completed cause of death (Item 23e) (Type, Print) 30. Neme

Funeral

Director

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I Director: After this ad in by the funeral d

To the Hospital o within 24 hours eff To the Funeral DI completely filled in

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The law requires that the death certificate be exact

Box 68760.

P.O.

Records,

Vital Physician: certific director,

of

Division

the Medical Examiner must be notified at

the Maryland

filed within 72 hours efter

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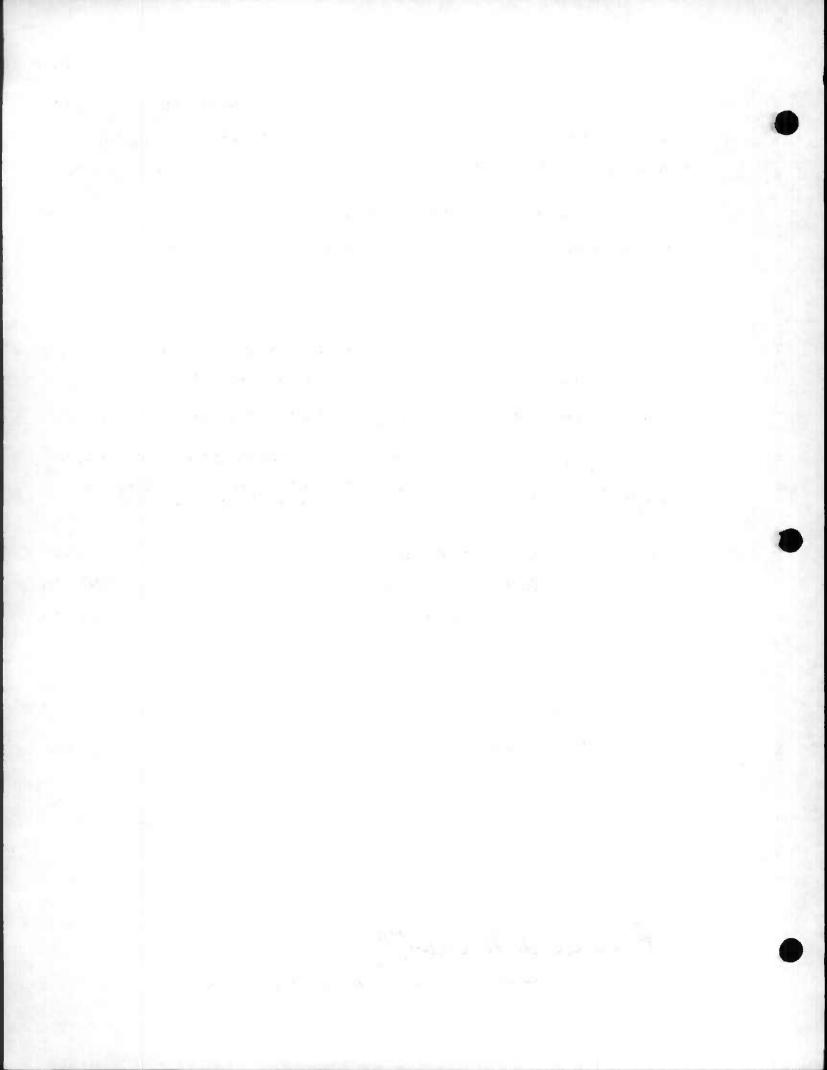
Baltimore, Maryland

31. Date filed (Month, Day, Year) State AUG 26 Registrar

Lawrence D. Marcus MD



10313 Georgia Ave. Silver Spring Md 20902



		State of Mary		artment of rtificate of		d Mental H	ygiene 9 8 Reg. No.	2	7478
	1. Decedant's Nama (First, Middla, Last	"				2. Data of D	eath Dey	Yeer	3. Tima of Death
hysician /Medical	STEWART	E. S	SHRADER			AUG.		1998	12:25PI
xaminer	4a Facility Nama (If not institution, give	street end numbar)			4b. City, Town,	or Locetion of Dec	th 4c. County	of Death	
	MONTGOMERY			1 10 1 1 1 1 1 1	OLNEY			GOME	
erai tor	5. Social Security Number 6. Sa	M 2□F 6]	yrs. last birthday) Yrs.	Months Deys		Min. (Month, D	25, 1936	9. Birinpia Countr	aca (Stata or Foraign y) VA •
	232-54-4655 Susual Rasidanca of Decedant								
	10a. Stata 10b. County	100	c. City, Town or Lo	ocation				10	d. Insida City Limits
tor	MD. MONTGO	MERY		KENSING	TON				1X Yas 2 No
Director	10e. Street and Number			10f. Zip Coda			10g. Citizen of V	Vhat Counti	ry?
Funeral L	4009 LAWREN	CE AVE.		20	895	U.S	S.A.		
1110	11. Marital Status	12. Was Decedant Evar Armed Forcas?	in U,S. 13.	Was Decedant of If Yas, specify Cul	Hispanic Origin' ban, Maxican, P	? (Specify Yas or Nuerto Rican, atc.)	lo- 14. Rac Blac	e - Amarice k, Whita, at	
	1 Never Married 2 Married	1 ☐ Yas 2 🕅 No If Yas, Giva		1□Yas 25 No			Specify		7.00
	3 Widowad 4 Divorced	Year or Datas:		**			AON Wind of D		ITE
	15. Decedent's Edu (Specify only highast grad	la complatad)	16a. Dece (Giva	dant's Usual Occu kind of work done DO NOT use retin	ipation a during most of adl	working	16b. Kind of Business/Industry		
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marked other than "nature imatic event, the Medical To Be Completed	17. Fathar's Nama (First, Middle, Last)			PECTAL			Illa, Maiden Sumama)		
	STEWART	L. SHE	RADER		1000	VIRGINI	INIA TEETS		
	19a. Informant's Name/Relationship (T			ailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda)					
	JUDY SHRADE	R/WIFE		SAME A	S ITE	M #10			
	20a. Mathod of Disposition	2	Ob. Place of Dispo	osition (Nama of matory or other pl	ace)	Deta	20c. Location -	City or Tow	vn, Stata
	1 ☐ Burial 2 【A Cramation 3 ☐ I 4 ☐ Donetion 5 ☐ Othar (Specify,			RS CREM		8/25/9	8 RIVE	ERDAL	E, MD.
etached for use as the buriat-transit and property of the pro	23a. Part1. Entar tha diseese, or compshock, or heart failure. List only of the shock of the sho	a. A cute 1 Dua b. Corwnar Dua		dial I quanca of): A quance of):					triferyal Between Onsat and Death 7 days Years
sici	Part II. Other eignificant conditions co	23b. DI	23b. Did tobacco use contributa to the cause of deat						
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Completed by		THE STATE				24a. Wa	as an autopsy normad?	ava	re autopsy findings ilable prior to nplation of causa aath?
Ho						10	Yas 20 No	10	Yes 2□ No
Be C	25. Was cese refarred to medical axaminar?				26. Place of	Death (Check only	y one)		
To	1 Yas 2 No	Hospital: 1 Inpatiant	2□ ER/Outpatie	nt 3 DOA	thar: 4 Nursi	ng Homa 5 🗆 Ra	sidance 6 Oth	ar (Specify)
	27. Manner of Death 1 Natural 5 Panding 2 Accident invastigation	28a. Data of Injury (Month, Day Yea	ar) 28b. Tima o	W	uryat ork? □Yas 2□No		28d. Describe how injury occurred		
Certification:	3 ☐ Suicida 6 ☐ Could not be datarmined	28a. Place of Injury - building, atc. (S	At homa, farm, st pecify)	raat, factory, office	9		(Straat and Numl Town, Stata)	ber or Rural	Routa Number,
edicai (sician: To the bast of my Inar: On the basis of axa and manner stated.							
Me	29b. Signature and title of certifier				nse number		29d. Dete signe		
	1 Motor			DI	8612	Md.	Aufur.	+ 22	, 1998
	30. Name and address of person who co	omplated cousa of death	(Itam 23a) (Type,	Print) Execut	time Blu	d. Roci	kville M	1 2	2286

Registrar

(Month, Day, Year) AUG 25 1998

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	State of Ma	arylan					fental Hygi	ene 9 8	27479		
			Ce	ertificate c	of Deat	h	Re	g. No.	1-4 1 1 7 2		
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Fecility Name (If not institution, g	ive street end number)				4b. City,	Town, or L	ocation of Deeth	4c. County	of Deeth		
Genesis Elderca	are						pring	Mont	gomery		
Social Security Number 6 14-96-7173	Sex 7. Age 1		est birthde) 57 Yrs.	Months Deys Hours Min. (Month, D					9. Birthpleca (State or Foreig Country) Trinidad		
sual Residenca of Decedent											
a. State 10b. County		10c. City	, Town or I	Location					10d. Inside City Limite		
MD Prince	Georges	Ade.	lphi						1 ☐ Yes — N		
e. Street and Number				10f. Zip Cod	е		10	g. Citizen of V	Vhat Country?		
9270 Adelphi	Road #101			20	783			US	SA		
Maritel Status	12. Wes Decadent I Armed Forces?	Ever in U,	S. 13	. Was Decedent	of Hispanic (Origin? (Sp	ecify Yes or No-		a - American Indien, k, White, etc.		
1 ☐ Never Married A Married				1 ☐ Yes 2√CM					: Indian		
3 ☐ Widowed 4 ☐ Divorced	Year or Detes:			TEL TOS ZALIN	NO Specia	у.		Specify	HIGHAN		
15. Decedent's (Specify only highest of			(Giv	edent's Usual Oc re kind of work do	ne durina m	ost of work	sina 1	6b. Kind of Bu	usiness/Industry		
Elementery/Secondary (0-12)	5+)	life.	DO NOT use re	tired)							
12			Di	etitian					lealth Care		
17. Father's Name (First, Middle, Last)							e (First, Middle, M	eiden Surnem	10)		
Gokool Mahara	j				Sur	nintr	а				
e. Informent's Neme/Reletionship	(Type, Print)						ral Route Number,				
al Beharry Sing	n		9270	Adelphi	Road	101	Adelphi	Marylai	nd 20/83		
e. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spe	city)	Ce	emetery, ci	position (Name of emetory or other NCOLN CR	plece) EMATOF		3/19/98 I	RENTWO	OD MARYLAND ERAL HOME, IN		
3a. Part1. Emer the thouse, or or shock, or heart failure.	mplications that caused by one gauss on each lin	I the death					AVE. SII		RING MD 2090 Approximete Interval Between Onset end Deeth		
nmediate Cause (Final sease or condition sulting in deeth)	a. MALNUT			equence of):					4YEARS		
	b. STROKE	STROKE AND DYSPHACIA									
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	DIABET	DIABETES									
	u										
	contributing to death be	ut not resu	ulting In the	underlying cause	given In Pa	rt I.	23b. Did to	3887	ntribute to the cause of deat		
art II. Other significant conditions											
art II. Other significant conditions							24a. Wes er		24b. Were eutopsy finding aveilable prior to completion of cause		
							perion		of dooth?		
							1 □ Ye	s 2XINo	of death? 1 ☐ Yes 2 ☐ No		
BLINDNESS					26 PI	ace of Dea	1 □ Ye	**	of death?		
BLINDNESS . Was case referred to medical exeminer?	Hospital:	.m. 2□	ED/Outpat	ient 3D DOA	0		1 ☐ Ye	9)	of death?		
BLINDNESS 5. Was case referred to medical	28e. Dete of Inju	ry	ER/Outpeti 28b. Time Injury	of 28c. I	0	Nursing H	1 □ Ye	nce 8 🗆 Oth	of death? 1 □ Yes 2 □ No er (Specify)		

Physician/Medical Examiner within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be datached for use as the burial-transit The law requires that the death certificate be asscuted Be Certification: To

by

Completed

Medical

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physicien:

State

Registrar

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JONES, 31. Dete filed (Month, Day, Year) AUG 25

tle of certifier

James

29b. Signature

GARY W.

Director

Funerai

by

Completed

Be

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Physician

/Medical

Examiner

Funeral Director

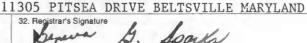
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiens. Important: If fear 27 is a metked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, it is bedies Examiner mass to protest

Physician

/Medical Examiner

Baltimore, Maryland 21215-0020

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30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

MD

porks

29c. License number

D30111

29d. Date signed (Month, Day, Year)

AUGUST 24, 1998

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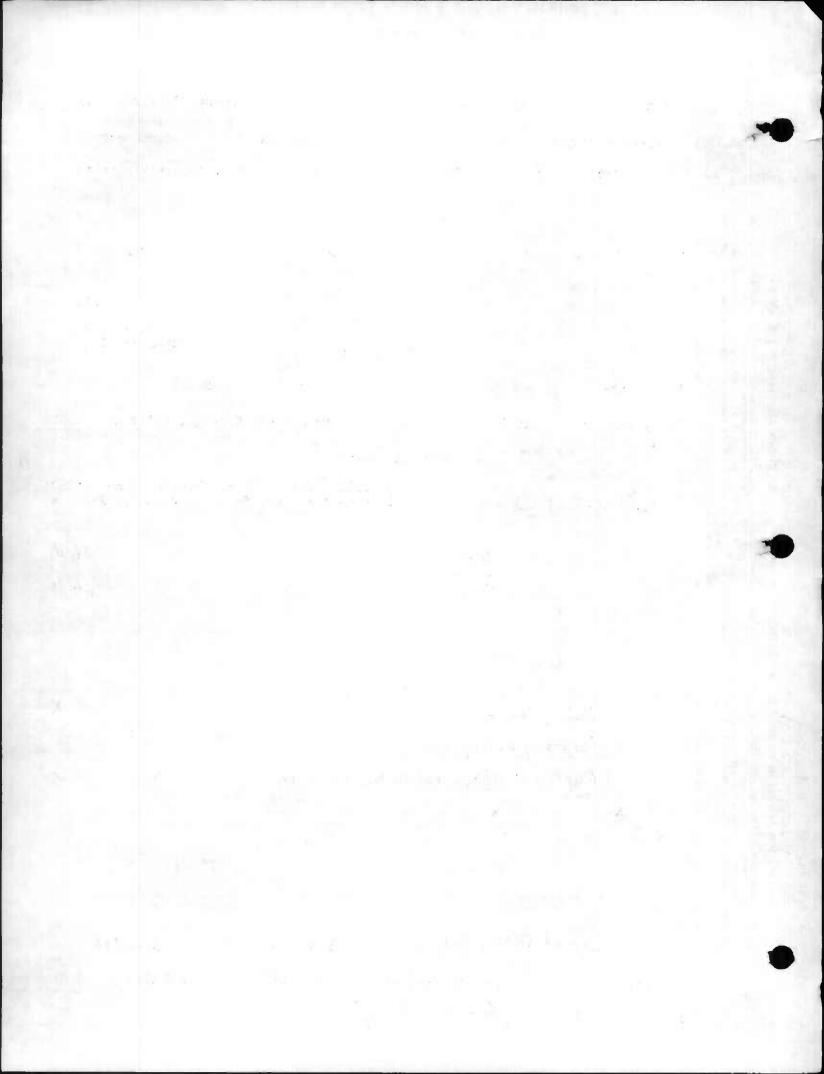
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death August 20 , 1998 ear **Physician** Soloway, Sr. Michael 10:20 PM /Medical 4b. City, Town, or Location of Deeth 4a Fecility Name (If not Institution, give street end number) 4c. County of Deeth Examiner Montgomery Bethesda Suburban Hospital If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Yeer)
Dec. 18, 1919 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** Hours Days 1 M 2 F Months Russia 78 Director 360-28-7790 Usual Residence of Decedent permit. Peges 1 end 2 should be filed within 72 hours effer death with the Maryland Department of Health end Mantel Hygiene. Important: if item 27 is merked other than "natural", or items 23s or 28s-4 show any injury or other traumatic avent, it is Medical Expriser must be not filed at once. 10c. City. Town or Location 10d. Inside City Limits 10e Stete 10b. County Yes 2□No Directo Illinois Cook Chicago 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 60634 3255 N. Oconto Avenue Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 2 No If Yas, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, 11. Marital Status Black, Whita, etc. 1 Never Married 2 Married FU Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: b 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) (Give kind of work done during most of working life. DO NOT use retired) Office Supply Elamantary/Secondary (0-12) College (1-4or 5+) Manufacturing Machinist 8 18. Mothar's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) (unknown) Adele Alex Soloway 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Steta, Zip Coda) 19a. Informant's Name/Relationship (Type, Print) 3255 N. Oconto Avenue, Chicago, Illinois Henny Soloway (wife) 20b. Place of Disposition (Neme of cemetery, cremetory or other piece) 20e. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 8-25-98 River Grove, Illinois 4 ☐ Donation 5 ☐ Other (Specify) Elmwood Cemetery 21. Signature of Funeral Service Licansee 22. Name and Address of Facility Schielka Addison Street Funeral Home 7710 West Addison Street, Chicago, Illinois Approximate Intarval Batween Onset end Death 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lina. Physician /Medical Immediate Cause (Final disease or condition resulting in death) 26 ds Examiner Due to (or as a consequence of): 26 ds Examine neumo ma The law requires that the death certificate be executed ettending physicien end for use es the buriel-transit Sequentially list conditions, if any, laading to immadiala cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequança of): Records, P.O. Box 68760 Physician/Medical Due to (or es e consequence of) signed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Kidney failure þ Coronary artery disease 24b. Wara autopsy findings evellable prior to completion of cause of death? 24a. Was an autopsy performed? Completed certificate has b lirector, page 2 sl Ruptured abdominal asitic aneurysm 1 Yes 2 No 1 ☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifical completely filled in by the funeral director, 25. Was casa raferred to medical examiner? Be 26. Place of Death (Check only ona) To Hospital: 1 KInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Dey Year) 28b. Time of injury 28d. Describe how Injury occurred 27. Manner of Death 28c. Injury et Work? Certification: Division 1 Natural 5 Panding investigation 1 Yes 2 No 2 Accident 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide Placa of Injury - Al home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledga, death occurred at tha tima, data and place, and dua to tha cause(s) and mannar as stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, daath occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifiar edicai (Check only one) 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier ind Beck, Mo 15 D 46052 30. Name and addrass of person who completed cause of death (Itam 23a) (Type, Print)

Sitep Beun Beun 8600 old George town 8600 Old Georgetown Road, Bethesda, MD 20814 31. Date filed (Month, Day, Yeer) 32. Registrar's Signature State AUG 24 1998 Registrar



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Aug.23,1998 10:46am Charles Lee Street /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, giva straat and number) Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Dey, Year) 5. Social Sacurity Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□ F Days Yrs. 48 103-38-9641 **Director** Nov. 20, 1949 New York Usual Rasidance of Decedent the Manyland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f ehore the Medical Examiner must be notified at 1 Yes 2 No Directo MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11235 Oak Leaf Drive permit. Pages 1 and 2 should be filed within 72 hours efter death a Department of Haalth and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a any injury or other traumatic event, the Medical Experiment management. U.S.A. 20901 Funeral 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian. Black, White, atc.
Black 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1⊠ Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Spacify only highest grada completed) 16b. Kind of Business/industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Nursing Assistant Private 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be 2 Laura M. Hobbs Charles R. Street 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Intorment's Name/Relationship (Type, Print) 11235 Oak Leaf Drive, Silver Spring, MD 20901
and Disposition (Name of Date 200. Location - City or Town, State Cammy L. Street -niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chambers Crematory Aug. 25 Riverdale, MD 22. Name and Address of Facility Chambers Funeral Home 21. Signature of Funeral Service Licensee unetal 5801 Cleveland Ave., Riverdale, MD 20737 xurul os M1014 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximata Interval Between Onset and Death **P.hysician** /Medical Immediate Cause (Final diseasa or condition resulting in death) NON-HODGKIN'S LYMPHOMA 5 months Examiner Due to (or as a consequence ot): Examiner SYNDROMIE UNKNOWN ACQUIRED IMMUNE DEFICIENCY certificeta be axecuted physician and s the burial-trans Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence ot): Box 68760. Physician/Medical Due to (or as a consequence of): 88 esn for signed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other elgnificant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 1 Yee 2 No 3 Probably 4 Unknown by Division of Vital Records, 24b. Were autopsy tindings available prior to should Completed 24e. Was en autopsy performad? completion of cause of death? pege 2 has and No 1 Yes 1 ☐ Yes 2 ☐ No or Attending Physician: director 25. Was cese reterred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3K DOA Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 1 Yes 200 No Lo funerai 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 1 Neturel 5 Pending aftar death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicida 28e. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify) 4 Homicide 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. 29a. Certifier edical completely (Check only one) To the To the To the 29c. Licanse number 29d. Date signed (Month, Day, Year) 29b. Signatura and title of certifier D35087 Aug. 25, 1998 30. Name and s of person who completed cause ot death (Item 23a) (Type, Print) Joseph J.Genovese MD 2121 Medical Park Dr. Silver Spring Md 20902 32. Ragistrar's Signature 31. Date tiled (Month, Day, Yeer) State AUG 26 Registrar

and the second TANK II THE SHEET IN STREET The arms of the second of the The Company of the co alest Michigan Committee and the second

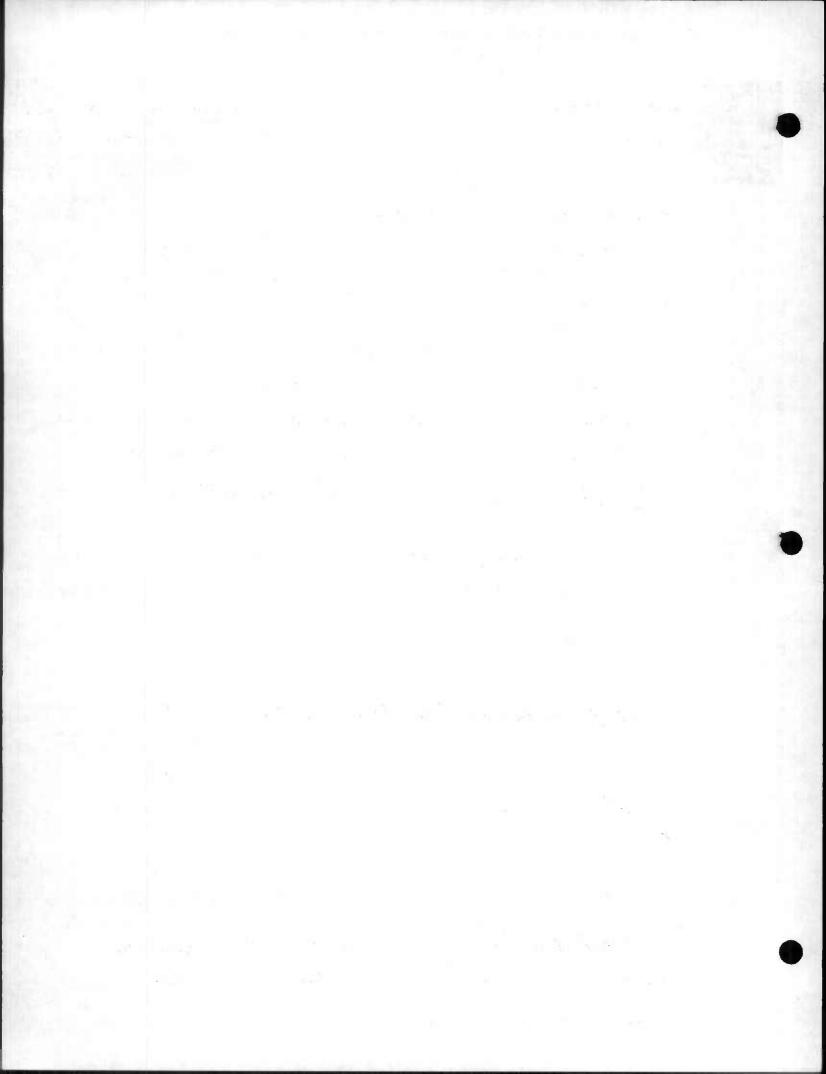
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3 Time of Death **Physician** Albert O. Schmitz Aug. 24, 1998 /Medical 09:05pm 4e. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth Examiner 4c. County of Deeth Silver Spring Holy Cross Hospital Montgomery If Under 1 Yeer | if Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year)

April 4, 1912 5. Sociel Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1₽M 2□ F Months Yrs. 86 Illinois 324-01-3402 Director Usual Residence of Deceden death with the Merylend 10e. Stete r than "natural", or items 23s or 28s-f show the Medical Exercises must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Montgomery Silver Spring 1 ☐ Yes 2 No Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 14400 Homecrest Road 20906 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours efter 1 Never Merried 2 Married 21215-0020 White 1 ☐ Yes 2 No Specify: Completed by 3 Midowed 4 ☐ Divorced Decedent's Usuei Occupetion
 (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry U.S. Coast and 15. Decedent's Education (Specify only highest grade completed) i Hygiene. College (1-4or 5+) Elementery/Secondary (0-12) Geodetic Survey .. Pages 1 end 2 should be filed witnest of Health end Mental Hygien tant: If Item 27 is marked other theury or other traumatic event, the Cartographic Engineer Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Otto Francis Schmitz Mamie Brackly 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13228 Bellevue Street, Silver Spring, MD Albert D. Schmitz 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 1 ☐ Buriei 2 X Cremetion 3 ☐ Removei from Stete 8-28-98 permit. Page Depertment of Important: If any fnjury or once. Beltsville, Maryland Chesapeake Crematory 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, Maryland 20910 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** /Medicai Immediate Ceuse (Final Malons diseese or condition resulting in deeth) Examiner Examiner The lew requires that the death certificate be executed buriel-trensit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): P.O. Box 68760, Physician/Medicai Due to (or es e consequence of): detached for use es Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown radisardia Records, Completed by page 2 should be 24b. Were eutopsy findings evailable prior to completion of ceuse of deeth? 24e. Wes en eutopsy performed? 1□ Yes 2 No certificate 1 ☐ Yes 2 ☐ No of Vital or Attending Physician: funeral director. 25. Wes cese referred to medical examiner? Be 26. Plece of Deeth (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpetient 3 DOA this 28e. Dete of Injury (Month, Day Year) 27. Menney of Deeth 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation After Division 1 Neturel s efter death. 1 Yes 2 No 2 Accident 6 ☐ Could not be determined n 24 hours efter des re Funeral Directo pletely filled in by th 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 29e. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. Medicai To the Hosp within 24 ho To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date and place, end due to the ceuse(s) end menner stated. 29d. Dete signed (Month, Day, Year) 29b. Signature and tplgfof certific 29c. License number no 2338 Aug. 25, 1998 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Richard P.Delaney MD 9801 Georgia Ave #109 Silver Spring Md 20902 32. Registrer's Signeture 31. Dete filed (Month, Day, Year) State

DHMH 16 Rev 6/95

Registrar

AUG 2 6 1998



If Under 1 Year

10f. Zip Code

20735

1 Yes 2 No Specify:

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Days

Months

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Month Day AUGUST 24 1998 JERRY LAMONT SMITH 3:40 PM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death

CLINTON

If Under 24 Hrs.

Hours

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

8. Dete of Birth (Month, Day, Year) July 5 1951

PRINCE GEORGE'S

10g. Citizen of What Country?

14 Race - American Indien

Bleck, White, etc.

Specify: Black

16b. Kind of Business/Industry

DC Government

USA

9. Birthplace (State or Foreign

Washington, DC

10d. Inside City Limits

Yes 2□No

Physician /Medical Examiner 1. Decedent's Name (First, Middle, Last)

579-68-0593

10e. Street and Number

11. Marital Status

10a. State

Director

Funeral

þ

Usual Residence of Decedent

1 □ Never Married 2 □ Married

3 Widowed 4X Divorced

Elementary/Secondary (0-12)

10b. County

Maryland Prince George's

Southern MD 9211 Stewart La

15. Decedent's Education (Specify only highest grade completed)

SOUTHERN MARYLAND HOSPITAL CENTER

1₩ 2□ F

Mariner Health of

12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates:

College (1-4or 5+)

Funeral

Director the Maryland "natural", or items 23a or 28a-f ahow death

pemit. Pages 1 and 2 should be filed within 72 hours after c Depertment of Health and Mentai Hygiene. Important: if Item 27 is marked other than "natural", or here any injury or other traumatic event, the Health Earning

Baltimore, Maryland 21215-0020

Box 68760.

P.O.

Records.

Division of Vital

Physician /Medical Examine

physician and the burial-transit The law requires that the death certificate be asscuted certificate has been signed by the irector, page 2 should be detached Attending Physician: 1 funant After a effector: Afr To the Hospital or A within 24 hours effer To the Funerel Direct Completely filled in b

Completed 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Carl T. Smith 19a. Informant's Name/Relationship (Type, Print) Constance F. Smith (Sister) 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State Metropolitan Crematory 8-27-98 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Fundral Service Licensee 22. Name and Address of Fecility Eberwein Mortuary M00173 benu disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, art taiture. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Acquired Due to (or es e consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events passitions) Due to (or es e consequence of): Physician/Medical that initiated events resulting in death) Last Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. þ Completed 1 ☐ Yes 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27, Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 Deaturat 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number

7501

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Suresh A. patelmo

AUG 2 8 1998

31. Date filed (Month, Day, Year)

7. Age (In yrs. last birthday)

Clinton

10c. City. Town or Location

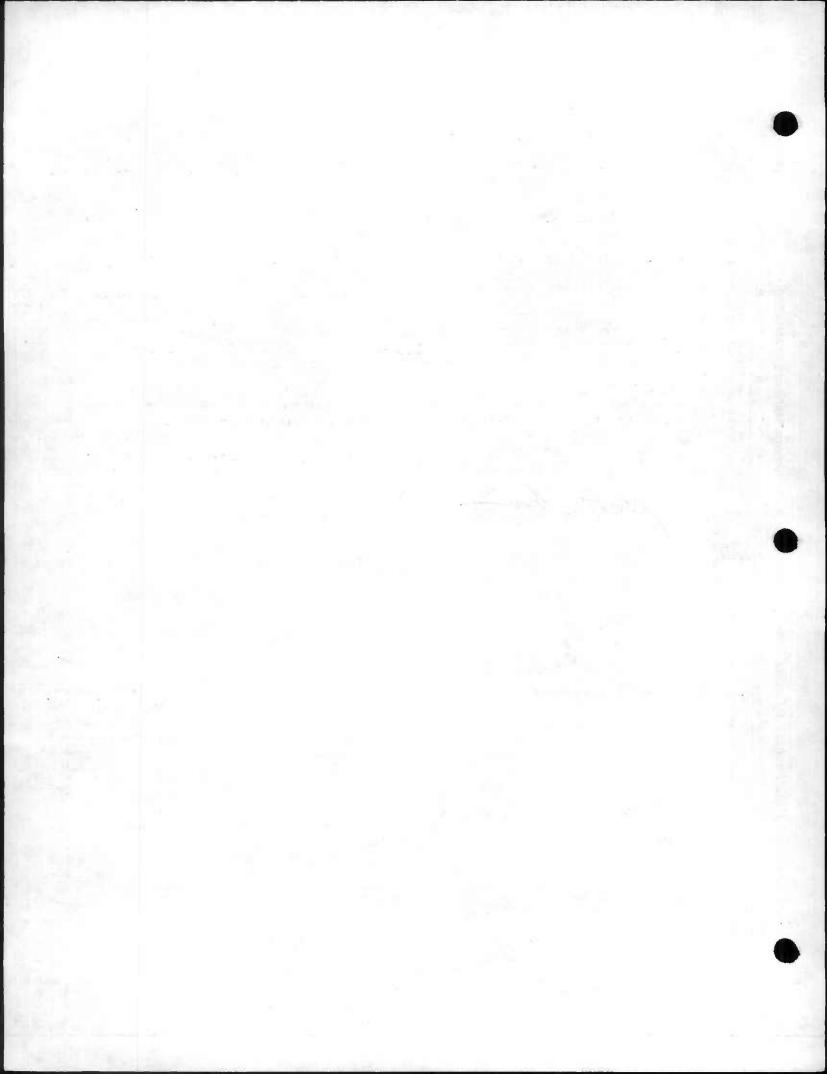
Laborer

47

Delois Mathis Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2411 Ewing Av Suitland, MD 20746 20c. Location - City or Town, State Alexandria, VA 4433 White Pls La White Pls., MD 20695 Approximete tntervat Between Onset and Death immuno deficien Syndrims years 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 Olo 3 Probably 4 Unknown 24b. Were autopsy findings eveileble prior to completion of cause of death? 24a. Wes an autopsy performed? 21300 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Scrifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year) 046478 8.2688

State Registrar

Surretts Rd # 307, Clinton, mo 20 735



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Month **Physician** Fern Brinsfield Suhr 21.45 19, 1998 August /Medical 4a. Facility Neme (If not Institution, give street end numbar) 4b. City, Town, or Location of Death **Examiner** 4c. County of Deeth Dorchester General Hospital Cambridge Dorchester If Under 1 Yaar | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) | July 24, 1920 6. Sax 7. Age (In yrs. lest birthdey) Funeral Birthplece (Stete or Foraign Country) 1 M 2 X F 218-10-7349 78 Yrs. Director Maryland Usuel Residence of Decedent death with the Maryland 10a State 10b. County 10c. City. Town or Location show 10d. Inside City Limits I is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at **Funeral Director** 1 ☐ Yes 2 No Maryland Dorchester Galestown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5834 Wheatley Church Road 19973 USA 12. Wes Decedant Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 Å No If Yes, Give Yaar or Dates: Was Decedant of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) Race - American Indian, Bleck, Whita, etc. Pages 1 and 2 should be filed within 72 hours after 1 Navar Married 2 Married Maryland 21215-0020 1 ☐ Yes 2 No Specify: White Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highast grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiena. Elementary/Secondery (0-12) College (1-4or 5+) 11 Office Manager Food Processing 17. Fathar's Name (First, Middle, Last) 18. Mothar's Name (First, Middia, Maiden Sumema) and Mental h Be Harry U. Brinsfield 2 Addie Wheatley 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Department of Health a Important: If item 27 is any injury or other trau Merle Wheatley/Legal Guardian 5525 Galestown Millhart Road, Seaford, DE 19973 altimore, 20b. Place of Disposition (Neme of cametery, crematory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Burlel 2 ☐ Cremetion 3 ☐ Ramovel from State Eldorado UMC Cemetery 8/23/98 Eldorado, Maryland 5 □ Other (Spacify) 21. Signatura of Funeral Service I 22. Name end Address of Fecility Zeller Funeral Home, P. O. Box 207, . Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, or heert failure. List only one cause carding 106 Main Street, East New Market, MD 21631 Approximeta Intervel Between end Deeth **Physician** Heart /Medical Immediete Ceuse (Finel whe disaesa or condition resulting in deeth) Examiner Due to (a) as a consequence of): Examiner Attending Physician: The law requires that the death certificate be executed buriel-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseas or injury that initiated events resulting in deeth) Last and Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760 ettanding physician Physician/Medical Dua to (or es e consequenca of): signed by the et Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ Completed 24b. Were eutopsy findinga available prior to completion of cause of deeth? 24a. Was en eutopsy hes 1 Yas 2 No certificate 1 ☐ Yes 2 ☐ No. funeral director, Be 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA Certification: To 1 Yes 2 No. Other: 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Menner of Deeth M 28d. Describe how Injury occurred 28e. Dete of Injury (Month, Day Yeer) 28b. Time of 28c. Injury et Work? within 24 hours after death.
To the Funeral Director: After completely filled in Proceedings 5 Pending Investigation MIA NA 1 ☐ Yes 2 ☐ No NID 2 Accident 3 Suicide 6 ☐ Could not ba 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Plece of injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and menner as stated.

| Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29e. Certifler (Check only one) 29b. Signatura and title of each 29d. Date signed (Month, Day, Yeer) DO50799

State Registrar

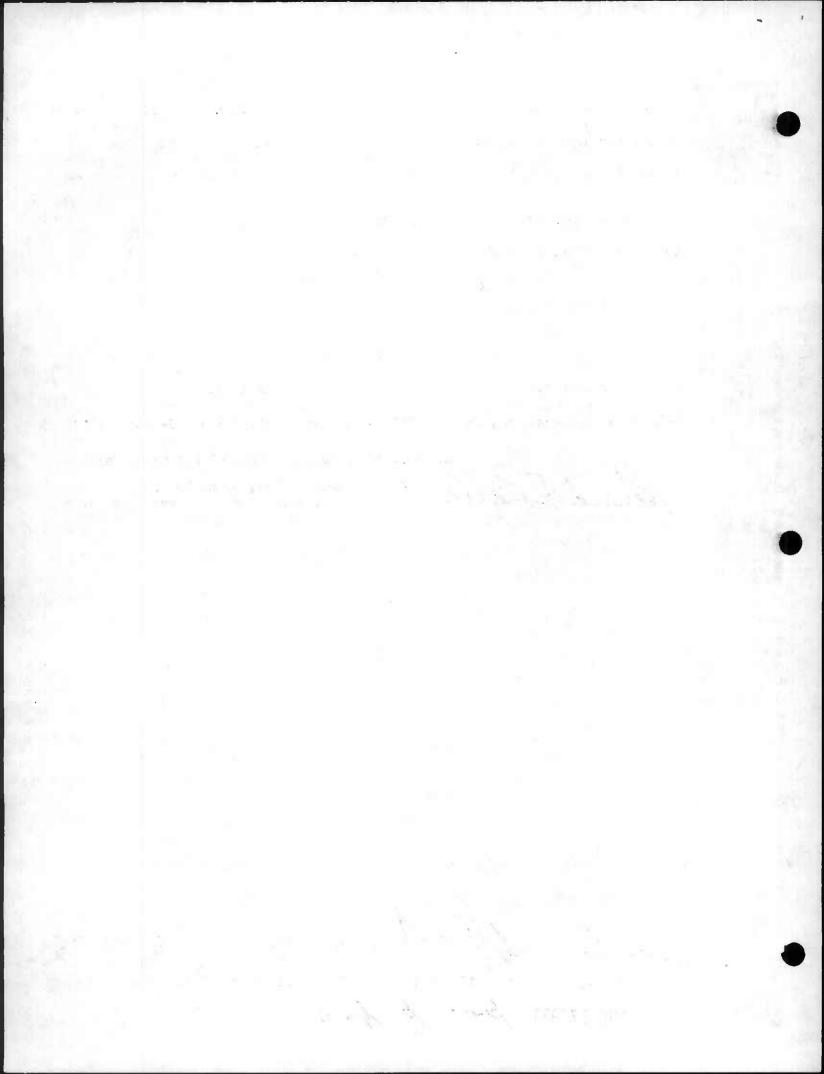
31. Dete filed (Month, Dey, Year) AUG 27 1998

SHIRIN

10 HAMMAD 32. Registrer's Signeture

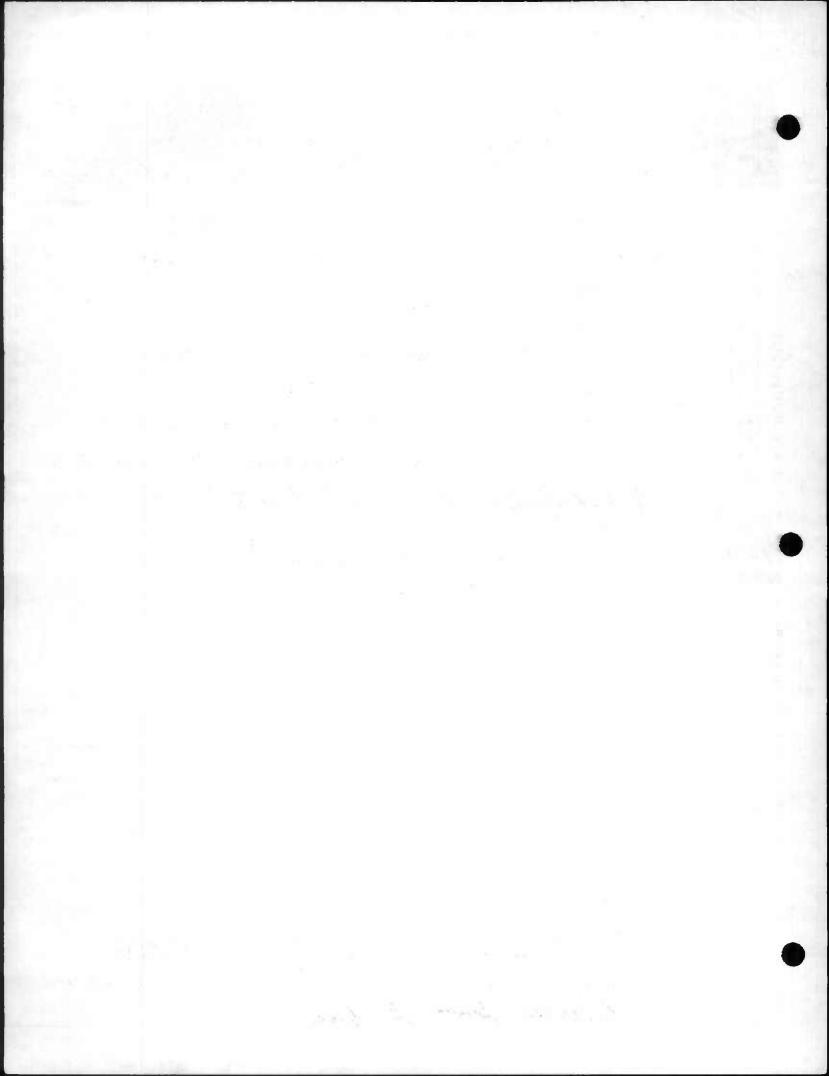
ime end address of person who completed ceuse of deeth (Item 23e) (Type, Print)

302 COLLINS AUE, HULLOCK, MD



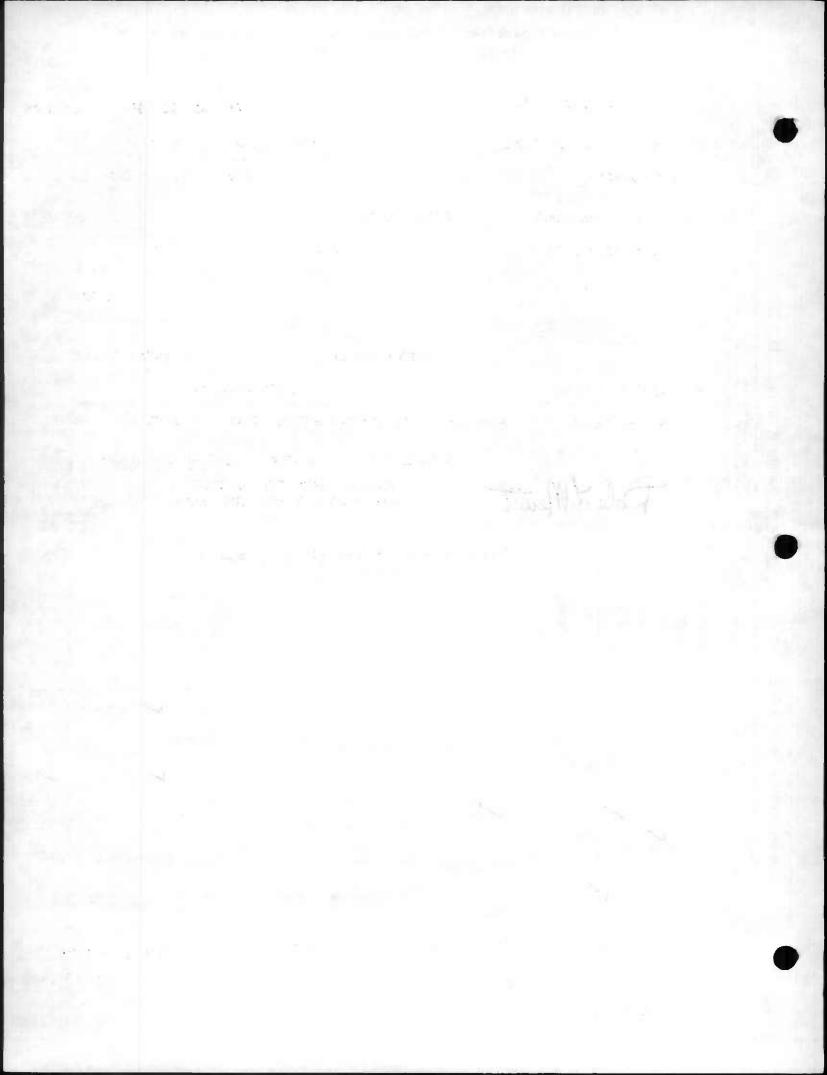
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** 1998 26, Guy Charles Slader August 16:18 /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Kent & Queen Anne's Hospital Kent Chestertown If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2□ F Yrs. 1917 Ft. Calhoun, NE Director 221-14-8376 80 December 28, Usual Residence of Decedent pernit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heelth and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Experies must be notified at once. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Queen Anne's Chestertown 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 330 River Road 21620 U.S.A. Funerai 11. Marital Status 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 17 Yes 2 No
If Yes, Give
Year or Dates: 1942-1946 Baltimore, Maryland 21215-0020 by 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) DuPont Accountant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Guy M. Slader Martha Mortensen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 330 River Road, Chestertown, Maryland 21620 Margaret Slader/Wife 20b. Place of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Cremation Center, LIC/August 27, 1998/Stevensville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility
Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620 that caused the death. Do not enter the mode of dylng, such es cerdiac or respiratory arrest, necessities on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Finel Concestive disease or condition resulting in death) **Examiner** Due to (or as a consequence of): Person FALLYTE The lew requires that the death certificate be executed physicien and s the buriel-transit Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical Due to (or as e consequence of): 98 attending usa Por ate has been signed by the a page 2 should be datached to Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert 1. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown P 24b. Were autopsy findings available prior to Completed 24e. Was en autopsy performed? completion of cause of death? certificate has 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attanding Physician: 24 hours after death. Funeral Director: After this certifica director. Be 25. Was case referred to medical exeminer? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident illed in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide 24 hours cai 29a. Certifier 1 Certifying Phyaicien: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end menner es steted. To the Hosp within 24 ho To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and fitte of certifier 29c. License number 29d. Date signed (Month, Dey, Year) d address of person who completed cause of deeth (Item 23e) (Type, Print) Yanas, M.D. Brown -100 31. Date filed (Month, Dey, Yeer) 32. Registrer's Signature State AUG 28 1998 Registrar



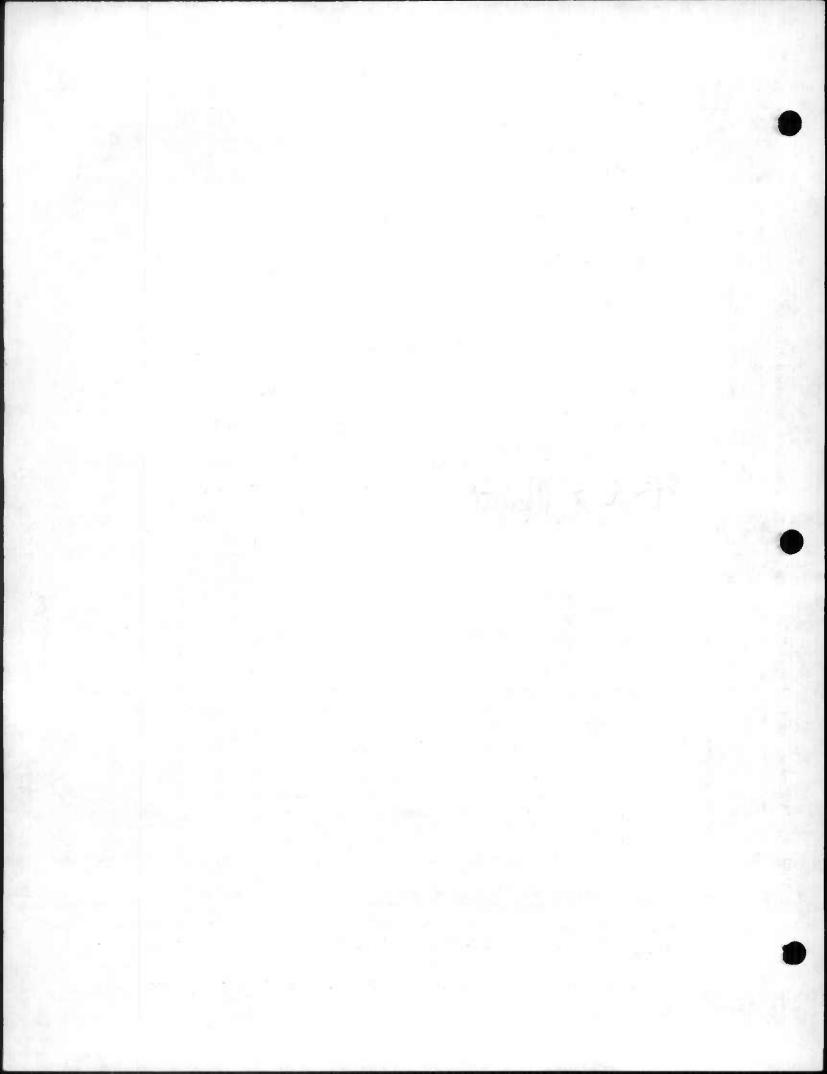
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

ysician Medical							Month	Dev	reer	3. Time of Death	
менкан	MYRA LOUISE	TRUKA					AUGUST			8:20 AM	
aminer	4a Fecility Name (If not institution, giv	re street and number)				4b. City, Town, or I	ocation of Deeth	4c. County of	Death		
	SACRED HEART HO	r 1 Year	00110	CUMBERLAND ALLEGANY If Under 24 Hrs. 8, Date of Birth 9, Birthplece (Stell							
ral tor	5. Social Security Number 279-07-1664 Usual Residence of Decedent	M 2∏F	86	Yrs. Months			(Month, Day	, Year)	Countr OHIO	ece (Stete or Foreign ry)	
ompleted by Funeral Director	10a. State 10b. County		10c. City, Town	n or Location					10	d. Inside City Limits	
to	MARYLAND ALLEGA	NY	CUMBE	RLAND						1∑Yes 2□No	
al Director	10e. Street and Number 1814 BEDFORD STRE	ET		10f. Z	p Code 21	502		U.S.		ry?	
by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent B Armed Forces? 1 Yes 2 N It Yes, Give Year or Dates:		13. Was Dec It Yes, sp		Hispanic Origin? (S een, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race Black, Specify:	White, e		
Completed	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16a.	Decedent's Us (Give kind of w life. DO NOT	ork done	during most of wor	king	16b. Kind of Bus	lness/Indu	ustry	
дшо	Elementary/Secondary (0-12)	College (1-4or 5				,u)		HOUSE KEEPER			
	12 17. Father's Neme (First, Middle, Last,)	HU	USE KEE	PER	18. Mother's Nan	ne (First, Middle,	Maiden Sumeme,		LEK	
other traumetic event, the Ma	FRANK E. RUTTER					KITTY	Y JOHNSON				
	19a. Intorment's Name/Relationship (Type, Print)	19b	. Mailing Addre	s (Stree	t and Number or Ru	ral Route Numbe	r, City or Town, S	tete, Zip (Code)	
	JAMES E. TRUKA	HUSBA	AND 18	B14 BEDI	ORD	STREET C	UMBERLAN	D MARYLA	ND 2	1502	
Y	20a. Method of Disposition 1 Burial 2 □ Cremetion 3 □ 4 □ Donation 5 □ Other (Specification)		cemeter	Disposition (No. 1) Dispos	other pla	AUGUST 2	Date 5 1998 E	30c. Location - C		vn, State	
SUCE.	21. Signature of Funeral Service Licer	erult		404 D	ECAT	ess of Facility DAMS FUNE UR STREET	CUMBERI	AND MARY			
	23e. Pert1. Enter the disease, or com- shock, or heart failure. List only	plications that caused one cause on each lin	the death. Do i	not enter the mo	de of dy	ing, such as cardiac	or respiratory an	rest,		Approximate Interval Between Onset end Death	
an ai	Immediate Cause (Final	TDIA	DATH	C PUI	MO	NARY F	BRASI (1	5 YEARS	
er	disease or condition resulting in death)	α.	Due to (or es e	A Part of the Part		10/11-	110100-13			70 (03	
iner		b									
Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Disease or injury c.										
/Medical Examir	that Initiated events resulting in death) Last	d	Due to (or as a d	consequence of	:						
Iciar	Part II. Other elgoificant conditions of	ontributing to death by	tributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of deeth?			
y Physician/M		on this day of the second of	at not roodining in	Tato dilgonying			101		3 🗆 Prob		
To Be Completed by Physician/M							24a. Was perfor	an autopsy med?	eve	re eutopsy findings illable prior to appletion of cause leeth?	
EO							101	es 20No	1 🗆	Yes 200	
Be	25. Wes case reterred to medical examiner?						eth (Check only o	ne)			
2	1 Yes 2 10	Hospital:		-	UA		_	lenca 6 □Othe)	
Certification:	27. Manner of Deeth 1 Matural 5 Pending investigation		Year) 28b.	Time of njury M	28c. Inju Wo	ork?] Yes 2 □ No		now injury occurre			
Certific	3 Suicide 6 Could not be determined	28e. Plece of Injubuliding, etc		irm, street, tacto	ry, office		28f. Location (S City or Tox	Street and Numbe m, State)	r or Aural	Houte Number,	
Medical		nysician: To the best of niner: On the basis of and manner sta	examination an								
M	29b. Signature and title of certifier	Dalazo		2	9c. Licen	ise number		29d. Date signed	(Month, L	Day, Year)	
	Mond	Kish? !	CIM		US	0844		AUGUS'	r 20	1998	
1	30. Name and audress of person who	completed cause of de	eeth (Item 23e)	(Type, Print)		0 0	ON DRIVE				



State of Maryland / Department of Health and Mental Hygiene

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	Physic /Medi		DOROTHY	MAY	TURANO						Month AUGUST	Day 16 1	Yaar 998	11:29 PM
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П	, Funeral		5. Social Sacurity Nu 214-07-56		6.Sax 1□M 2√2F		(In yrs. last b 81	virthday) Yrs.	If Undar 1 Yaa Months Days			rth ay, Year)	9. Birthpla Countr	ca (Stata or Foraig
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Division	or Attending effer death. Director: Affer 3 in by the fune	Certification:	3 ☐ Suicida 4 ☐ Homlcide	6 Could not datarmine	ad 28a. Plac	a of Injury	y - At homa, f (Spacify)	arm, stra	at, factory, office		28f. Location (City or To	Street and Numb wn, State)	oer or Rural F	Routa Number,
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	To the Hospital or Attending Physician: The law within 24 hours after dash. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2	edical	29a. Certifiar 1 (Check only 2]	☐ Certifying i	aminer: On that	a best of a basis of e nnar state	xamination ar	e, death nd/or inva	occurred at the ti astigation, in my	me, data and place opinion, daath occu	a, and dua to tha urred at tha tima,	cause(s) and me data and place,	anner as state and dua to th	ed. na ceuse(s)
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E.	Registr	ar	AUG 1 8	1998	pere	···	Ø.	10	all					



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Dev Year Physician BRINKLEY TAYLOR SR. 2330 14,1554 Aubust /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1₩ 2□ F Vre 50 Director 218-58-0049 June 10, 1948 Maryland Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show 12 Yes 2 No Director Maryland Wicomico Salisbury 10e. Sfreet and Number 10f. Zip Code 10g. Citizen of What Country? 234 5303 Eastwood Circle 21804 USA Funerai Name 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Datas: 5 5-0020 1 ☐ Yes 2 ☑ No Specify: Specify: 2 3 ☐ Widowed 4 ☐ Divorced White "neturel" Be Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 21215 I Hyglene. filed within Elementary/Secondary (0-12) College (1-4or 5+) Laborer Burial Vault Co. Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be sent of Health and Mental int II item 27 is marked or Norris Taylor Mary Elizabeth Abbott 19a. Informant's Name/Raletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Mae Taylor/Wife 5303 Eastwood Circle, Salisbury, MD 21804 aftimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Mathod of Disposition Date 20c. Location - City or Town, Stete 1 Burial 2 □ Cremetion 3 □ Removel from State Department of Important: If St. Paul Church Cemetery 8/18/98 Wenona, MD 4 ☐ Donation 5 ☐ Other (Specify) a of Juneral Service License 22. Name and Address of Fecility Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21804

Do not enter the mode of dying, such as cardiac or respiretory arrest,

Ag Approximete Interval Between Onset and Death **Physician** Immediata Causa (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, ited Hickman tha Due to (or es e consequence of) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. page 2 should be detached 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. Be Completed by 24b. Were autopsy findings available prior to 24a. Wes an eutopsy performed? completion of cause of death? 1 ☐ Yes 2 No 1 ☐ Yes 2 No certificate of Vital al or Attending Physician: The state death. 25. Was casa raferred to medicat axaminer? 26. Placa of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1. Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manger of Death 28a. Date of fnjury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident completely fiiled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital e within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the causa(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner steled. 29a, Certifier Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3354 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) ANTHONY FREY SALISBURY. 106 MILKOLD ST Suite 104 21804 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 1 9 1998 Registrar

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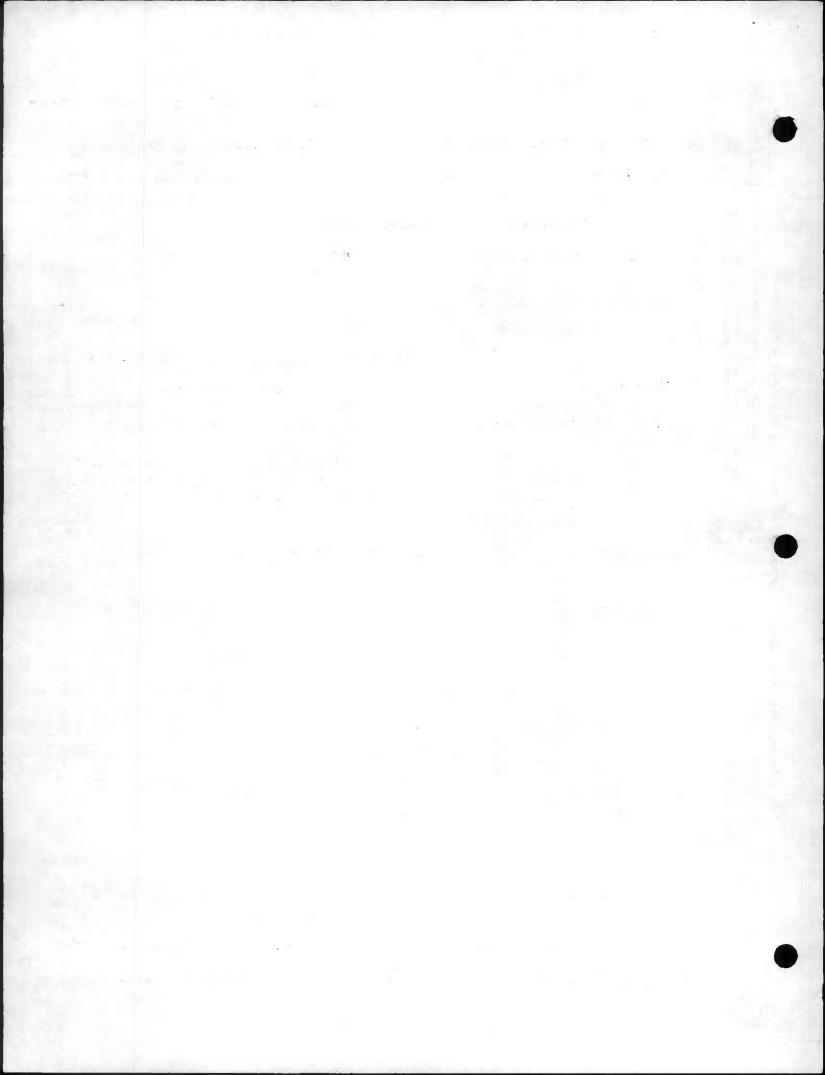
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Dey Year **Physician** Edna Follett Tadlock August 20, 1998 1:00 AM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) 5. Social Security Number If Under 1 Year 7. Age (In vrs. lest birthday) **Funeral** 1□M 210 F Months Deys 87 December 31, 1910 Rhode Island Director 217-44-5518 the Merylend 10a Stete 10c. City. Town or Location 10d. Inside City Limits worde 10b. County "natural", or items 23a or 28a-f show 1 ☐ Yes 21 No Maryland Montgomery Chevy Chase Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 3409 Thornapple Street 20815 United States death Funerai 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. filed within 72 hours after (Hygiene. 1 Never Merried 2 Married The Baltimore, Maryland 21215-0020 If Yes, Give Year or Dates: 1 Yes 2 No Specify: þ White 3 X Widowed 4 ☐ Divorced marked other than "natur matic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) 16e. Decedant's Usuel Occupation (Give kind of work done during most of working lifa. DO NOT use retired) Elamentery/Secondary (0-12) College (1-4or 5+) 4 Homemaker Own Home permit. Peges 1 and 2 should be file Department of Health and Mental Hyg Important: If flem 27 is marked othe any injury or other traumatic event, pnce. 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) William H. Follett Margaret M. Killum 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) William H. Tadlock/ Son 6406 Kings Landing, Alexandria, Virginia 22310 20b. Place of Disposition (Neme of cemetery, cremetory or other place) August 20,1998 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 X Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Montgomery Crematorium, Inc. Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ 21. Signature of Funeral Septice Licenses Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, M00689 Bethesda, Maryland 20814-3501 disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, allure. List only one cause on each line. Approximate Intervel Between Onset and Deeth **Physician** /Medical Immediate Ceuse (Finel PIRATION Examiner Due to (or es e consequence of): Examine EREBRAL | NF ARC
Due to (or es e consequence of): physician end s the burial-transit that the death certificate be executed Sequentially list conditions, if eny, leeding to immediata cause. Enter Undarlying Couse (Disease or Injury that initiated avants rasulting In daath) Last 1AL FIBRILLATION WITH EMBOLUS
Due to (or as a consequence of): Physician/Medicai TERIOSCLEROTIC HEART DISEASE for use as 20 YEARS 23b. Did tobacco use contribute to the cause of death? ed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yee 2 No 3 Probably 4 Unknown signed be det P 24b. Were eutopsy findings available prior to 24e. Was en eutopsy performed? Completed peen completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No this certificate director. 25. Wes case referred to medical examinar? Be 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residance 6 Other (Specify) 2□ No 2 1 ¥ Yas 1 ☐ Inpatiant 2 ☑ ER/Outpatient 3□ DOA After thi 27. Manner of Deeth 28e. Deta of Injury (Month, Day Year) 28c. tnjury et Work? 28d. Describe how Injury occurred 28b. Time of Certification: 5 Panding Investigation Hospital or Attending 1 DNatural 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 Sulcide 6 Could not be 28f. Location (Street end Number or Rural Routa Number, City or Town, Stata) 28e. Plece of tnjury - At home, farm, street, fectory, office building, atc. (Specify) 4 Homicida To the Hospital or within 24 hours aft To the Funerel Dicompletely filled in 1 🛣 Certifying Phyeician: To the best of my knowledge, deeth occurred et the tima, dete end plece, and dua to the ceuse(s) end menner es steted. 29a. Certifier edicai 2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, data and place, and due to the ceuse(s) end menner stated. 29d. Date signed (Month, Dey, Year) 29b. Signature and title of Artifice 29c. License number 20 of markets of person who completed cause of death (Item 23a) (Type, Print) mo. # 6000 EXEC DSEPH ONNOR 300 31. Dete filed (Month, Dey, Yaar) 32. Registrer's Signeture State AUG

Registrar

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naea #	10e.,8/25/98,G.F.,1	<u> </u>	Cei	rtificate of	Death	2. Data of Das	Reg. No.		3. Tima of Death
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Medical/ Examiner	4a Facility Nama (If not institution, give	a street and number)	W 4		4b. City, Town, or I	ocation of Death	4c. County	of Death	
	11700 Old Colum	bia Pk, #100	3	2016	Silver	Spring	Mon	tgome	ry
uneral	5. Social Sacurity Number 8. S	₩ SUE	rs. last birthday)	If Undar 1 Year Months Days	If Undar 24 Hrs.	8. Data of Birth (Month, Day	, Year)	9. Birthple Counti	aca (Stata or Fora
irector	217-44-2448 Usual Rasidance of Decedant	X W 201	6 Yrs.			Dec 6,			York
ž u	10a. Stata 10b. County	10c.	City, Town or Lo	cation				10	d. Inside City Lim
northed at	Maryland Montg	omerv	Silve	er Spring					1 □ Yas 2√□ I
or 28a-f	10e. Street and Number		DIIVO	10f. Zip Coda			10g. Citizan of V	What Count	ry?
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al, or items 23s or 28s-f si Examiner must be northed by Funeral Director		12. Was Decadant Ever in Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Giva Yaar or Datas:		Was Dacedant of I f Yas, specify Cub 1 ☐ Yas 2 🎇 No	Hispanic Orlgin? (S ean, Maxicen, Puert Specify:	pacify Yas or No- o Rican, atc.)	14. Rac Biad Specify	e - Amarice ck, Whita, a	tc.
			16a. Dece	dant's Usuel Occu	pation		16b. Kind of Bu	usinass/Indi	White
	(Specify only highast gra Eiamantary/Secondary (0-12)	Collega (1-4or 5+)	(Giva	kind of work dona DO NOT usa retire	during most of world)	king			
a mo	Clamanary/Secondary (5-12)	7	Pro	fessor			Univer	sitie	S
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					Susa	an Selfr	idge		
traumetic	19a. Informent's Name/Ralationship (** .			t and Number or Ru				
any injury or other tra	Terresa C. Whit		b. Place of Dispo		Ave, Sil	Lver Spr	ing, MD		
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de .	4 □ Donation 5 □ Other (Specification 21. Signature of Funeral Service Licer				Crematory			twood	
any -	Delan J	Damelo		Nama and Address 1800 New	Hampshir	nes-Rin			
cian	23a. Part1. Entar tha diseasa, or com shock, or haart failura. List only	plications that caused tha done causa on each line.	eath. Do not ent	ar tha moda of dyi	ing, such as cerdiad	or raspiratory ar	rest,		Approximata Intarvai Batwaan Onset end Deeth
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ege C						101	as 2 No	1 🗆	Yas 2 No
director, paga To Be Com					26. Placa of Das	ath (Check only o	ne)		
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d in by the fu	3 Suicida 6 Could not b datarmined	28a. Place of Injury - A building, atc. (Spe	t homa, farm, sti ecify)	eat, factory, offica		28f. Location (S City or Tox	Straat and Numb yn, State)	ber or Rural	Routa Number,
completely filled in by the funeral Medical Certification:	29a. Cartifiar (Check only one) 1 Cartifying Ph	ysician: To the best of my inner: On the basis of axam and manner stated.							
Comp	29b. Signatura and titla of certifiar	4.4		29c. Lican	sa number		29d. Data signa	d (Month, L	Day, Year)
12	D. Vieramadily	a Reddy	MD	0	43464		August	21	1998
	30. Name and address of parson with VIKRWYADITYA - D. R.	complated ceusa of daath (I	Itam 23a) (Type,	Print) The, Sul	TE 303, 1	POLKVIL		D-20	852
State	31. Data filed (Month, Day, Year)	32. Ragistrar's Si	onatura	. Som					
- Ciuit		998 Denes							



State of Maryland / Department of Health and Mental Hygiene AMEND: #4C PER PHYSICIAN G764 10-16-98 WR. Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3 Time of Death Month **Physician** MARJORIE ELLEN WAGONER AUGUST 24 1998 1515 /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner SACRED HEART HOSPITAL CUMBERLAND MINERAL ALLEGANY If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) FEB.8, 1920 5. Social Security Number If Under 1 Yeer 9. Birthplece (State or Foreign 7. Age (In yrs. lest birthdey) **Funeral** Months Days Hours 1 M 2 F WEST VIRGINIA 232-26-0756 88 Yrs **Director** Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deportment of Health and Mantal Hygiane. Important: If tem 27 is marked other than "netural", or items 23a or 28a-f show any injury or other traumatic event. In Maryland 10 and Injury or other traumatic event. 10e State 10h County 10c. City. Town or Location 10d. Inside City Limits ty Yes 2 □ No Director WV MINERAL FORT ASHBY 10e. Street end Number 10g. Citizen of Whet Country? 10f. Zip Code DAN'S RUN ROAD 26719 U.S.A. Funeral 12. Wes Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. 11. Maritei Stetus 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 1□ Yes 2√ No Specify: Specify: WHITE þ 3€ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 10 MACHINE OPERATOR NATIONAL JET CO. 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Lest) D. HOMER WEAKLAND ELIZABETH BROWN 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) CAROLYN KESNER/GRANDDAUGHTER P.O. BOX 256, FORT ASHBY, WV 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20e. Method of Disposition 1 St Burial 2 □ Cremetion 3 □ Removel from State 8/27/98 FORT ASHBY CEMETERY FORT ASHBY, WV 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility
UPCHURCH FUNERAL HOME, INC. 21. Signature of Funeral Service Licensee scruce P.O. BOX 1260-FORT ASHBY, WV 26719 23a. Pert1. Enter the of sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete tritervel Between Onset end Deeth **Physician** Vascular Accident Immediate Ceuse (Final disease or condition resulting in deeth) /Medical Examiner Physician/Medical Examiner physician and the bunal-transit The law requires that the death certificate be executed Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as e consequenca of) 60 esn ed by the e Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the ceuse of death? ardiomyopathy 1 Yes 2 No 3 Probably 4 Unknown signed t by 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? Fibrillation 24a. Wes en eutopsy performed? Completed s cardificata has b director, page 2 s 2 No 1 ☐ Yes 2 No or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ☐ ER/Outpetlent 3 ☐ DOA this 28a. Dete of Injury (Month, Dey Yeer) funeral 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: Aftar 1) Neturel 2 Accident 5 Pending Investigetion eftar death. Director: Af 1 ☐ Yes 2 ☐ No n 24 hours efter des ne Funerei Director nialely filled in by th 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es stated. Medicai To the Hosp within 24 hor To the Fune completely fi (Check only one) 2 Madicat Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end piece, end due to the cause(s) and menner steted. 29b, Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) AUGUST 30. Neme and eddress of person who completed countries (Item 23a) (Type, Print) Seton 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State AUG 2 6 1998 Registrar DHMH 16 Rsv 6/95

Please Type or Print in Black Indelible

State of Maryland / Departmen

Certificat

	Mental Hygiene	773.000	27100
e of Death	Reg. No.	20	27492
	2. Date of Death Aug 16, 199	8 Year	3. Time of Death 12:51a.m.

Physician /Medical **Examiner**

Funeral Director

permit. Peges 1 end 2 should be filed within 72 hours effer death with the Maryland Depertment of Health end Mental Hygiene. Important: If Item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumstic event, the Medical Elegicies mainton mainted. Baltimore, Maryland 21215-0020

Physician /Medical **Examiner**

The law requires that the death certificate be executed ettending physician end for use es the buriel-tran director, page 2 should l or Attending Physician: efter death. eral Diractor: After thi filled in by the funeral

Division of Vital Records, P.O. Box 68760, WATACH, JOHN To the Hospital o within 24 hours eff ... To the Funeral DI completely filled in

187-01-9717

1. Decedent's Name (First, Middle, Lest) John Frank Watach 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Memorial Hospital ER Cumberland Allegany 5. Social Security Number 6. Sex FD M 2□ F If Under 1 Year | If Under 24 Hrs. Date of Birth Month, Day Year 1919 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Days 187-01-9717 78 Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Cumberland Allegany Yes 2 No **Funeral Director** 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 622 E. Oldtown Road 21502 USA 12. Was Decedent Ever In U,S. Agned Forces? 1 1 Pyes 2 □ No If Yes, Give Yeer or Dates: WWII Race - American Indien, Bleck, White, etc. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 Yes ZONO Be Completed by Specify: Specify 3 Widowed 4 Divorced white 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Ret. Postal Clerk Post Office 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Frank Watach Mary (Elko) 2 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Rodella Watach-wife 622 E. Oldtown Road Cumberland MD 21502 20b. Place of Disposition (Neme of cemetery, cremetory or other piece)

Rocky Gap Veterans Cem. 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 20c. Location - City or Town, State 08/19 Flintstone MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Scarpelli Funeral Home, P.A. Cumberland MD 21502 23e. Part1. Enter the disease, or combilcations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Carcinoma of Lung 13 Years Due to (or as a consequence of): Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Dfd tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Be Completed by 24b. Were eutopsy findings available prior to 24a. Was an autopsy performed? Certification: To

				1 ☐ Yes 20 No	of death?
25. Was cese referred to medical			28. Place o	of Death (Check only one)	
examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3	DOA Other: 4 Nurs	sing Home 5 Residence 6 Othe	r (Specify)
27. Menner of Death 1 Natural 5 Pending 2 Accident investigation		28b. Time of Injury M	28c. Injury at Work?	28d. Describe how Injury occurre	ed
3 Suicide 8 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, street, fac fy)	tory, office	28f. Location (Street end Number City or Town, State)	er or Rural Route Number,
29a. Certifier (Check only one) 1 Certifying Physical Example	sicien: To the best of my kno fner: On the basis of examina end manner stated.	owledge, deeth occurr ation end/or investigat	red et the time, date and tion, In my opinion, death	place, end due to the ceuse(s) end mer occurred at the time, date and place, a	nner as steted. nd due to the cause(s)

29b. Signature

29c. License numbe

Date signed (Month, Day, Year)

Williams Terry

32. Registrar's Signature

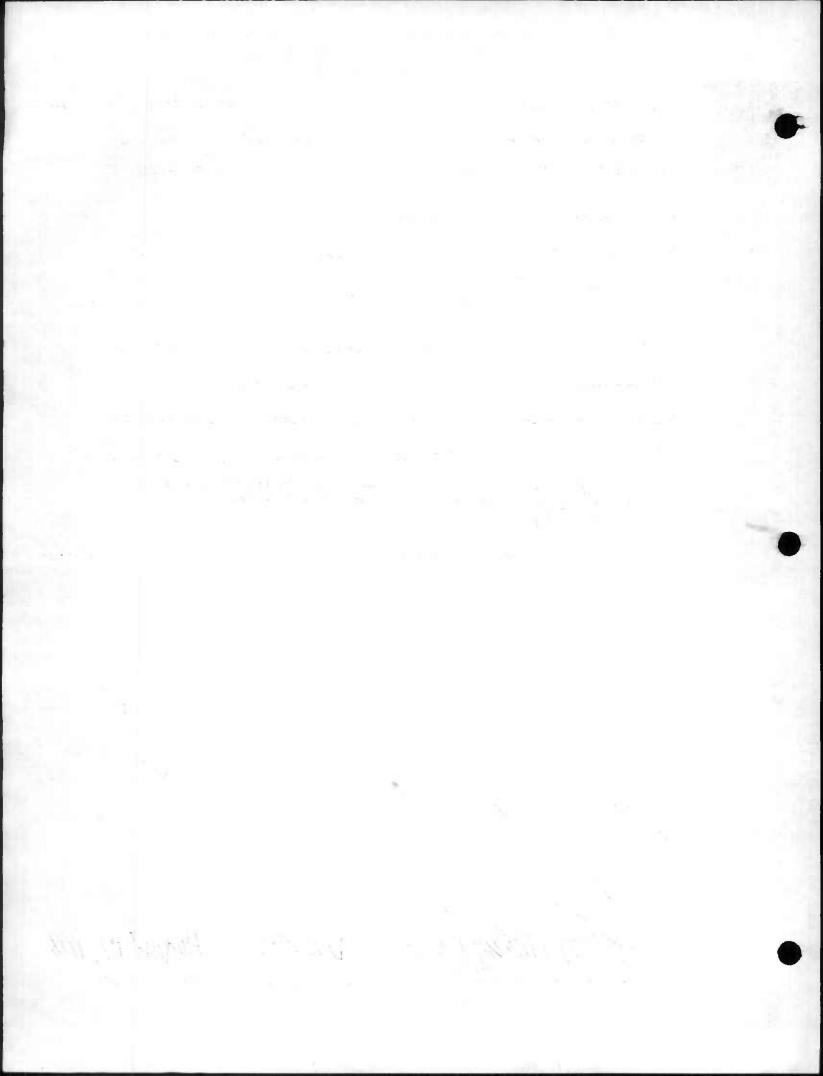
completed ceuse of deeth (ftem 23e) (Type, Print)

Memorial Hosp. Med Bldg Cumberland MD 21502

Registrar

State

Medical



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1 Decedent's Neme (First, Middle, Last) 2. Deta of Deeth 3. Time of Deeth Month **Physician** Wells August ober -a+ 0110 1998 /Medical 4b. City, Town, or Location of Deeth 4e. Fecility Neme (If not institution, give street end numbar) 4c. County of Death Examiner Haryland Medical System university of caltimore NIA 5. Social Sacurity Number 7. Age (In yrs. last birthday) If Undar 24 Hrs. Funeral Birthpleca (State or Foreign Country) 8. Dete of Birth (Month, Day, Yeer) 1 M 2 F Deys Director 579-40-6600 Oct. 6, 1932 Maryland 10a. State 10b. County 10c. City, Town or Locetion 10d. Inside City Limits items 23a or 28a-f si 1 ☐ Yes 2√ No Director Maryland Anne Arundel Lothian 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? death with 113 E Street Lyons Creek Park 20711 U. S. A. Funeral 12. Was Decedant Evar in U,S. Armed Forces? Was Dacedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) Race - American Indian, Black, White, etc. The Medical Examiner Pages 1 and 2 should be filed within 72 hours efter nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite 1 XXes 2 □ No If Yes, Give Yaar or Datas: Korea 1 □ Naver Married 2 □ Married 21215-0020 1 ☐ Yes 2 ☑ No þ Specify: Specify: 3 ₩Widowed 4 Divorced White Completed 16e. Decedent's Usuel Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest greda complated) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Truck Driver Trucking Company 6 traumatic event, Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mothar's Name (First, Middla, Maiden Sumema) Be Eleanore May Murray Harry Lewis Wells 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Department of Health ar important: if item 27 is any injury or other trau Adell E. Leonard/Daughter 132 A Street Lothian, Maryland 20711 20a. Method of Disposition 20b. Plece of Disposition (Nema of cemetery, crametory or other plece) 20c. Location - City or Town, State August 1 ☐ Burial 2 X Cramation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 18,1998 Clinton, Mary Tand Lee Crematory natory
22. Name end Address of Fecility Lee Funeral Home Caf Pert, P.A. 21. Signature of Funeral Service L 8125 So.Md.Blvd.Owings, Md. 20736 or the usease of complications that caused the deeth. Do not anter the mode of dying, such as cardiac or respiretory errest, heart hillure. List only one cause of each line. NA PROVED BY MEDICAL Approximate Intervel Between **Physician** /Medical Immediate Ceuse (Finel diseese or condition resulting in death) Examiner Schemic Necrosis of
Due to (or es a consequence of): The law requires that the death certificate be executed Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in deeth) Lest bunal-tran and Vehicle Box 68760. totor Physician/Medical Due to (or es a consequance of): should be detached for Part II. Other eignificent conditions contributing to deeth but not resulting in the underlying cause given in Pert I. Records, P.O. 23b. Did tobacco use contributa to the cause of death? yd bengis 1 Yes 2 No 3 Probably 4 Unknown Coronary attery disease þ 24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? 24e. Wes en eutopsy performad? Completed Diffuse atherosclerosis major branch vessels Aorta and this certificate Division of Vital i or Attending Physician: efter death. Director: After this certifica 25. Wes cese referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Language 1 DOA 2 ER/Outpetient 3 DOA 10 1 Yes 2 No 27. Manner of Deeth 28e. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: 5 Pending investigation 1 Neturel Motor Vehicle Crosh August 8,1998 1600 PM 1 Yes 2 No 22 Accidant filled in by the 28e. Place of Injury - At home, farm, street, fectory, office building, atc. (Specify)

Street

28f. Location (Street end Number or Rural Routa Number, City or Tawn, State)

28f. Location (Street end Number or Rural Routa Number, City or Tawn, State)

28f. Location (Street end Number or Rural Routa Number, City or Tawn, State)

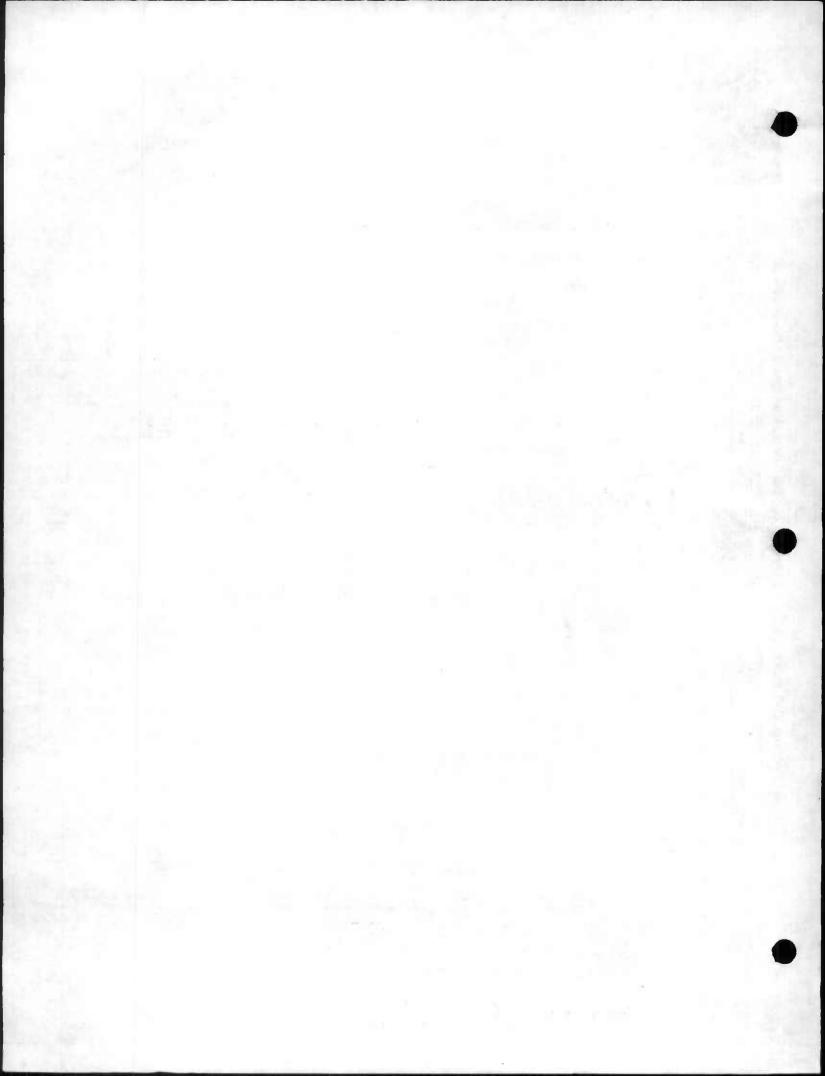
28f. Location (Street end Number or Rural Routa Number, City or Tawn, State)

28f. Location (Street end Number or Rural Routa Number, City or Tawn, State)

28f. Location (Street end Number or Rural Routa Number, City or Tawn, State) 6 Could not be determined 3 Suicide 4 ☐ Homicide To the Hospital within 24 hours or To the Funeral Completely filled Medical 29a. Certifier Examinar: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29b. Signature a 29d. Date signed (Month, Dey, Year) 023286 August 14,1998 30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print) 22 South Greene Street Baltimore, Maryland 21201 KON AM MYERS 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State 1998 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** Kitt Walker 400 91 2 /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Cheverly
If Under 24 Hrs.
Hours Min. Prince Georges Hospital Prince Georges If Under 1 Year 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Deys 1 M 2 F Yrs. Director 02/27/24 231-22-8829 Virginia Usual Residence of Decedent the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or flams 23a or 28a-f show the Wedical Exeminer must be notfled at Director 1 ☐ Yes 2 ☐ No Prince Georges Hyattsville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 5310 Emerson Street 20781 Funeral USA deeth 14. Race - American Indian, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Stetus 12. Was Decedent Ever in U,S. Armed Forces? pernit. Peges 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiena. Important: If Item 27 ia marked other than "natural", or Ite any Injury or other traumatic event, the Wedical Exercise. 1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Never Merried 2 ☐ Merried 21215-0020 1 ☐ Yes 2 ☐ No Specify: þ Specify: White 3☐Widowed 4☐Divorced Yeer or Detes: Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Domestic Baltlmore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harlan Woodard Nannie Penley 19a. Informent's Neme/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Otis Walker, Jr. / Son 1280 Neptune Lane Huntingown MD 20639 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Mathod of Disposition 20c. Location - City or Town, State 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) George Washinton Cemetery 8/24/98 Adelphia Maryland 21. Signatural Europeal Service Licenses 22. Name and Address of Fecility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave. Silver Spring MD 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or hear feilure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** /Medical Immediate Ceuse (Finel ordiac disease or condition resulting in deeth) Examiner Due to (or es a consequence of): Examiner Peritonitis **burial-transit** Sequentielly list conditions, if any, laading to immediate ceusa. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest and Perforated P.O. Box 68760, Physician/Medical Due to (or es e consequence of): Pert ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 2 3 Probably 4 Unknown 1 Yes 2 No Atheroscleratic Heart Discase Division of Vital Records. þ Sign 24b. Wera eutopsy findings eveilable prior to completion of ceuse of death? Completed 24e. Wes en eutopsy performed? Thrombocy to penia 1 Yes 2 No 1 Yes 2 No certificate or Attending Physician: funeral director, 25. Wes cese refarred to medicel axaminar? Be 26. Place of Death (Check only one) Hospitel: 15 patient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 1 Yes 2 No this 28e. Deta of Injury (Month, Day Year) 27. Manner of Deeth 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? Affer Naturel 5 Pending s after death. 1 ☐ Yas 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28a. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 4 Homicide filled in within 24 hours a To the Funeral D completely filled Hospital Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) end menner steted. 幸 29b. Signeture and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) D37934 10 30. Name and eddrass of person who completed ceuse of deeth (Item 23a) (Type, Print) 7500 Greenwax Ctr Dr. #430 Greenholt 100 20770 Irifaglio /D Stephanie 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State AUG 25 1998 Seper Registrar



Examiner Division of Vital Records, P.O. Box 68760 Attending

physician a the burlal-8 5 B signed b oertificate has ilrector, page 2 i 100 Affect death. 8 after Olivec

Physician

/Medical

Examiner

Funeral

Director

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Hygiene.

Pages 1 and 2 should be fill ment of Health and Mental H tant; If Item 27 is marked off lury or other traumatic even

Department o Important: If I any Injury or o

Physician

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72 hours after

Baltimore, Maryland 21215-0020

Director

Funeral

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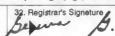
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31. Dete filed (Month, Day, Year)

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and title of cartifier



M.O

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

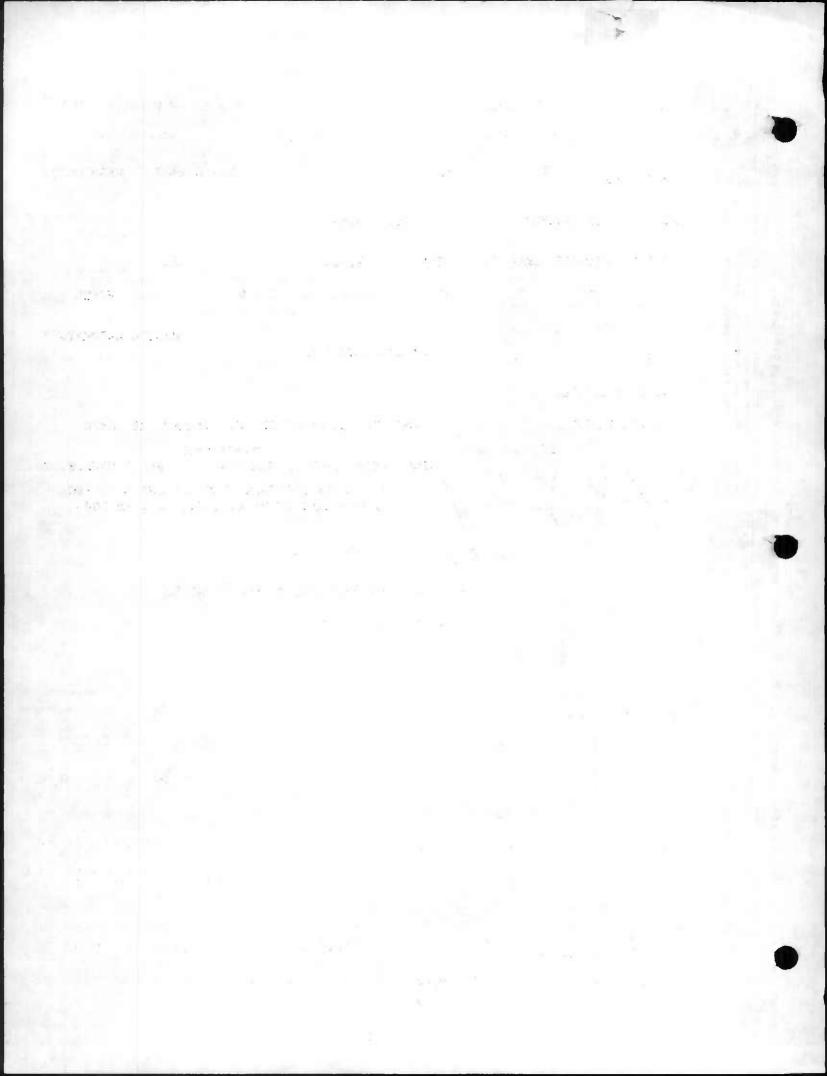
CALL MARGOLLI, MO 1/125 BOOKUILLE PIKE, POCKVILLE IMO 20852 socksi

29c. License number

D15236 DMt

29d. Date signed (Month, Day, Year)

AUGUST 21, 1999

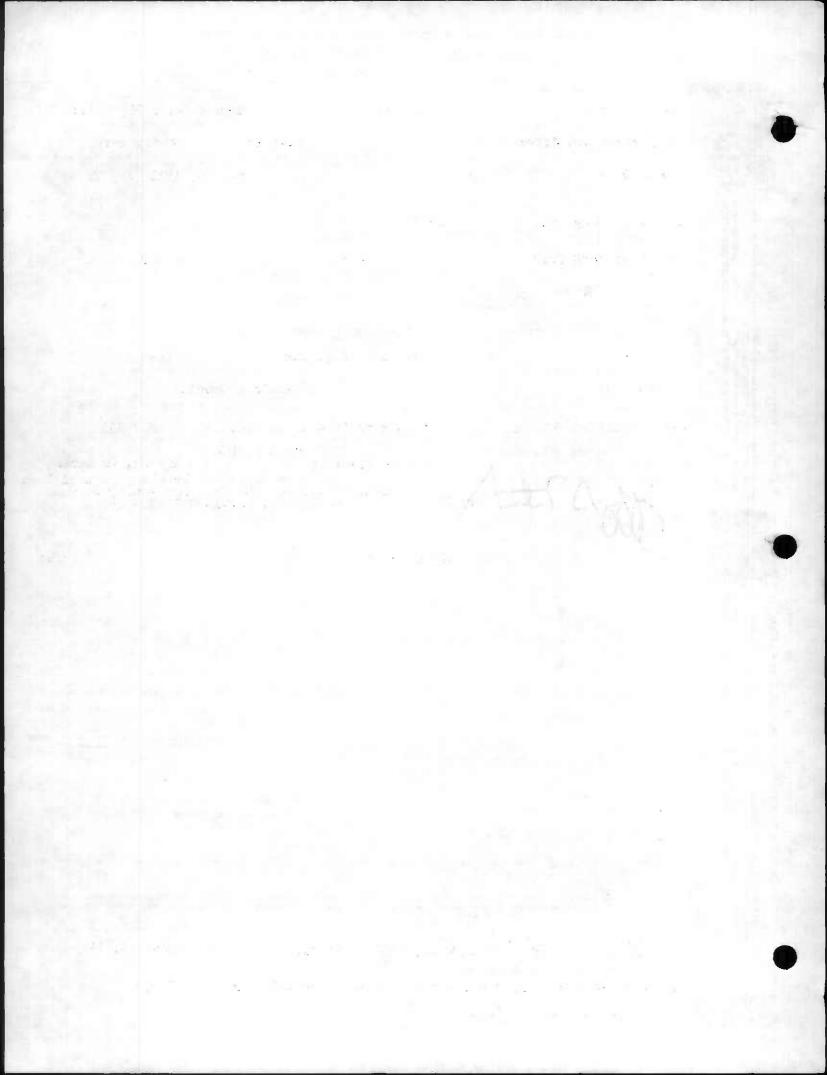


State of Maryland / Department of Health and Mental Hygiene ()

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		_	1. Decedent's Nema (First, Middla, L	est)			100					2. Data of C			View.	3. Time of Death
3.	Physiciar		Anthony James				Will	iams				Month August)ay 1QC	Yaar	6:15 PM
₹.	/Medica	11.0	la Facility Nama (If not institution, gr	ve street end nu	ımber)		,,	201110		4b. City, To		cation of Dec	-	c. County		
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3	Funeral			10 M 2□ F			lest birthdey Yrs.	Months	Days	Hours	Min.	8. Data of B (Month, L	ay, Yea	ir)		place (Stata or Foraign intry)
	Director		100-12-3436		75		115.					May 26	, 1	923	New	York
	D .	-	Usuai Residence of Decedent			10- 01	Town or I	tion								40d Incide Ob. I limbs
	thought a		10a. Stata 10b. County			Toc. City	y, Town or L	ocation								10d. Inside City Limits
	W T	3 1	Maryland Montgome	ry		Roc	kville	9								1 ☐ Yes 2X No
	or 28a-f s		10e. Street and Number	27-11				10f. Zip	Coda				10g. 0	Citizan of	Whet Cou	intry?
	with and and and and and and and and and and		4413 Haverford Dr	1170				208	5.2				TYm	ited	Char	
	ration of the result of the Maryland ration from 23s or 28s-1 show Exertine man be not red	5	11. Maritai Status	12. Was Dad	edant	Evar in U.	S. 13			Hispenic Ori	igin? (Spe	ecify Yes or N				ican Indien,
	5 2 2 3	5	1 Never Married 2 X Married	Armed F	orcas?	w Wor	1.4	If Yas, spec	cify Cub	an, Maxican	, Puerto	ecify Yes or N Rican, atc.)		Bla	ck, Whita	, etc.
20	urs eff		3 ☐ Widowad 4 ☐ Divorced	If Yas, G	iva			1 ☐ Yes	2 X No	Specify:				Specif	y: TTI	
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21215-0020	be filed within 72 hours efter tal thygiene. attural, or ite d other than "natural, or ite event, the Medical Examina Performal feed by E.		15. Decedant's E (Specify only highast g	ducation ada complated,)		16e. Deci (Giv	edent's Usua a kind of wo	al Occu rk dona	pation during mosi ad)	t of worki	ing	16b.	Kind of B	usinass/ir	ndustry
2	ithin	2	Elementery/Secondary (0-12)	College	(1-4or 5	5+)	life.	DO NOT us	sa ratire	ed)						
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pu	be file doth		17. Fathar's Neme (First, Middla, Las	t)						18. Moths	ar's Name	e (First, Midd	e, Maid	an Sumar	ma)	
<u>a</u>	should be filed within 72 hours eft of Mental Hygiene. merked other than "natural", or imetic event, tra Medical Examiration of the Medical Examiration of	5	James Pappas							Koula	a Zaf	firopo	los			
Maryland	2 should be filed with end Mental Hygiene. is marked other than aumatic event, us M		19a. Informent's Name/Relationship	(Type, Print)			19b. Mai	ing Addrass	(Stree	t and Numbe	er or Rure	el Routa Num	ber, City	y or Town	, Steta, Zi	ip Coda)
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e,	1 end Health em 27 other tr		Helen Williams/ W 20a. Mathod of Disposition	ire		20h P						Rockvi	LLe,	MD	20853	own, State
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P.O.	by th											10	7 Yes	2□ No	3□ Pr	obably 4% Unknow
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of Vital Records,	d by											24a. Wa	s an au	topsv	24b. V	Vare eutopsy findings
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ec	has the pas th														0	f death?
	The law requires the law requires the last been single 2 should the last th											10	Yas	2XI No	1	☐ Yes 2☐ No
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>	Physician: this certific ral director,	5	axaminar? 1 ፟X Yas 2 □ No	Hospitai:	Inpatie	ent 2	ER/Outpetic	ent 3 DC	DA Ot	her		ma 5XIRa		6 DOt	har (Spec	ifu)
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on	Afte func		1 Natural 5 ☐ Panding investigation		nth, De	y Year)	Injury	М		ork?]Yas 2∐	No					
S	tor:		2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not	ne -	4 1-1		ana falsa a					29f Location	/Ctroot	and Num	har or Pu	ral Routa Number,
Division	tal or Attending P rs efter death. al Director: After ti led in by the funera		4 ☐ Homicide determina			c. (Spacif)		traat, factory	у, опісе			City or T			Del Ul nu	rai nobia rumber,
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	houndrane it fill		29a. Cartifiar 1X Certifying P (Check only 2 Medical Exa													
	To the Hospital or Attending Ph within 24 hours effer death. To the Fureral Director: After th completely filled in by the funeral		(Check only 2 Medical Exa	end mar			HOLI SULTANI	ivestigation,	, in my	opinion, gaa	xiti OCCUFT	ou at tria time	a, ua(a 8	ind place,	, and dua	to tria causa(s)
	Vithir To th		29b. Signeture and title of cartifier	4	/		,	290	c. Lican	sa number			29d. 1	Data sign	ed (Month	, Day, Year)
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	ンナナー	-	· Imm	10/					174	, , , , 1			114	5456	23,	2770
		1	30. Nema and addrass of person who													
			David A. Holden,	M.D. 8	09	Veirs	s Mill	Road	, R	ockvi1	lle,	Mary1a	and	2085	1	

State Registrar

31. Data filad (Month, Day, Year)



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Dacedant's Nama (First, Middla, Lest) 2. Data of Daath 3. Tima of Death Month **Physician** HARRY WILSON 4:15 A.M. AUGUST /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Daath 4c. County of Death **Examiner** LORIEN FRANKFORD Home Baltimore City Baltimore City NURSIN 6 7. Aga (In yrs. last birthday) 5. Social Security Number 6. Sax **Funeral** 9. Birthplaca (Stata or Foreign 1QM 2□ F Months Days Baltimore, Maryland 219-30-2349 Yrs. Director Usual Rasidence of Decedant 10a. Stata 10b. County Pagas 1 and 2 should be filed within 72 hours efter daath with tha Marylen nant of Haaith and Mental Hygiena.
Intt: If Item 27 is marked other than "natural", or itams 23a or 28a-f show ury or other traumatic event, the Medical Examinat mant be notified at 10c. City. Town or Location 10d. Insida City Llmits Director Baltimore 1 ☐ Yas 2 ☑ No Maryland Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 21234-4951 8541 Morven Road Funeral 12. Was Decadant Evar in U,S. Armad Forces? 1 ☐ Yas 2 ☐ No If Yas, Giva 13. Was Dacadant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status 14. Raca - Amarican Indian. 1 Navar Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed by 3 Widowed 4 □ Divorcad 16a. Dacedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa ratired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) Collaga (1-4or 5+) Never Worked WA 17. Father's Nema (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumema) Be Walter David Wilson, Jr. Catherine Suzanna Leef P 19a. Informant's Name/Ralationship (Typa, Print) 19b. Mailing Addrass (Straat and Numbar or Rural Routa Number, City or Town, State, Zip Coda) Ruth A. Reinhardt (Sister) 8541 Moreven Road Baltimore, Maryland 21234-4951 20b. Pleca of Disposition (Nama of camatary, cramatory or other placa) 20a. Mathod of Disposition 20c. Location - City or Town, Stata permit. Pagas I Depertment of H Important: if ite any injury or ot once. 1 Burial 2 □ Cramation 3 □ Ramoval from State Gardens of Faith Cem. August 26, 1998 Baltimore, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signeture of Funaral Service Licansas 22. Nama and Addrass of Facility Lassahn Funeral Home, Inc. 7401 Belair Road Baltimore, Maryland 21236-4625 23a. Part1. Enter the disasse or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset and Death Physician /Medical Immadiata Causa (Final disaasa or condition rasulting in daath) Neck Cancer 4 week, **Examiner** Dua to (or as a consequanca of) Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, laeding to Immadiata causa. Entar Undarlying Cause (Diseasa or Injury that Initiated avants resulting In death) Lest for usa as the buriel-trar Dua to (or as a consequence of): of Vital Records, P.O. Box 68760, Dua to (or as a consaquance of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacço use contribute to the cause of death? Seizure diserder 1 Yes 2 No 3 Probably 4 Unknown by CaPID 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy this certificeta has 1 Yas 2 No 1 ☐ Yas 2 ☐ No Physician: Be 25. Was casa rafarred to madical axaminar? 26. Placa of Death (Check only ona) Other: 4 Nursing Homa 5 Rasidanca 6 Other (Specify) 10 1□ Yas 2☐ No 1 | Inpatiant 2 | ER/Outpatient 3 | DOA al or Attending Physical authority after death.

ii Director: After this ed in by the funarel d 27. Mannar of Death 28a. Data of injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Tima of 28d. Dascribe how injury occurred Division 1 ENatural 5 Pending invastigation 1 | Yas 2 | No 2 Accident 6 Could not be 3 ☐ Suicida 28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) 281. Location (Straet end Number or Rural Routa Number, City or Town, Stata) 4 Homleida To the Hospital o within 24 hours af To the Funeral D complately filled it 1 Certifying Phyalcian: To tha best of my knowledga, daath occurred at tha time, data and place, and dua to tha ceusa(s) and mannar as steted.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and dua to the ceusa(s) and mannar stated. 29a. Cartifier Medical (Check only one 29b. Signature and titla of pertifiar 29c. Licanse number 29d. Data signed (Month, Day, Year) 9/21 D43721-BACK Riven Neck Rd BANTO MD 30. Nama end eddrass of person who complated cause of death (Itam 23a) (Type, Print) Tanig Mahmood
31. Data filed (Month, Day, Year) 32. Regi P01-108 32. Registrar's Signatura State SEP 0 9 1998

DHMH 16 Rev 6/95

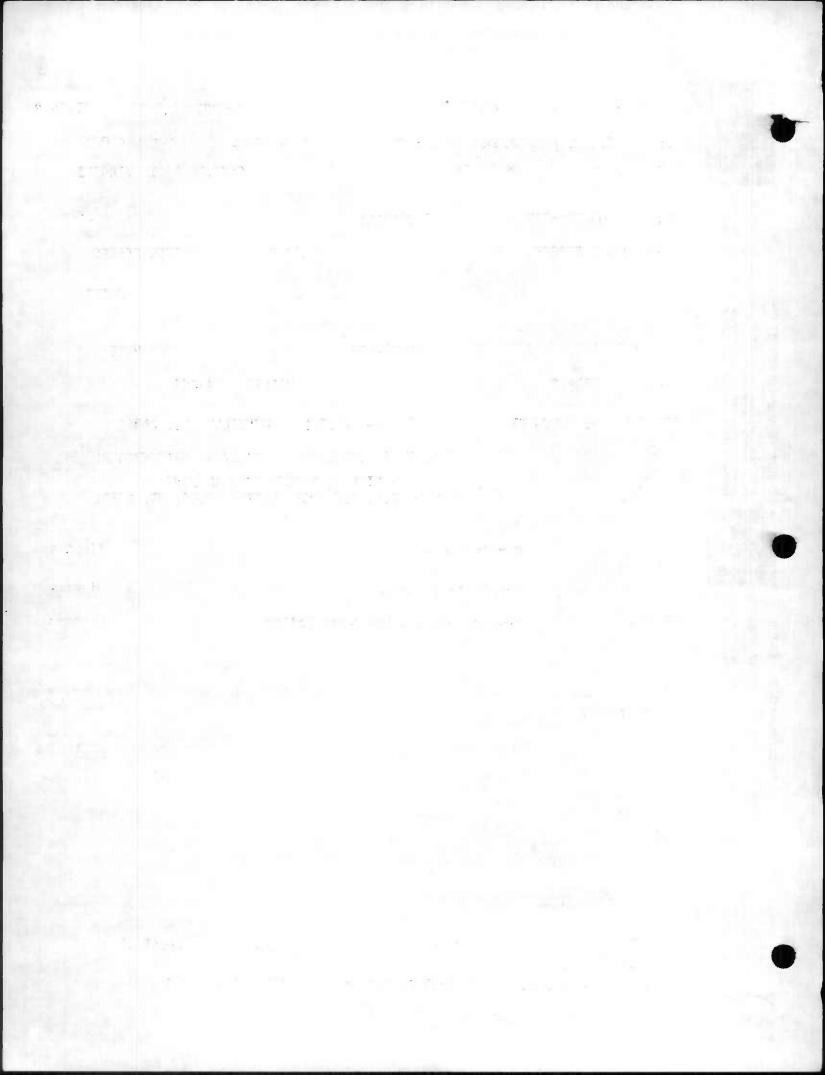
Registrar

the facilities and the second Militeration with the second s

		cate of Death	Reg. M	10. 98 2/498
Physician /Medical	1. Decedent's Name (First, Middle, Last) MARY V. WILLIAMS		AUGUST 21	Oay Year 3. Time of Deeth 17:34 PM
Examiner Funeral Director		ROCKV	TLLE	MONTGOMERY 9. Birthplece (State or Foreign Country) 921 VIRGINIA
Hygiene. ther than "natural", or Items 23s or 28s-f show ant, the Medical Examinet must be notified at a Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	n		10d. Inside City Limits
red at				Yes 2□No
al, or items 23a or 28a-f abov Examinet must be notified at by Funeral Director	10e. Street and Number 215 MONROE STREET	of. Zip Code 2085 0		Citizen of What Country? TED STATES
ofted Evaniver must	11. Maritel Status 12. Was Decedent Ever in U,S. Armed Forces? 1 Never Married 2 Merried 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	Decedent of Hispanic Origin, specify Cuban, Mexican, Forest 22 No Specify:	n? (Specify Yes or No- Puerto Ricen, etc.)	14. Race - American Indian, Black, White, etc. Specify: WHITE
edical	15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAN	s Usuai Occupetion of work done during most o IOT use retired) KER	f working	Kind of Business/Industry OWN HOME
8 8	DOD LIAMMAC	18. Mother's MAG	Name (First, Middle, Maid GIE BARNES	en Sumeme)
! 🧃	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Ac			y or Town, Stete, Zip Code)
int: If Itam 27 Ia marke iry or other traumatic TO	BETTY MONROE, DAUGHTER 20e. Method of Disposition 1 Buriet 2 Cremetion 3 Removal from Stete 4 Donation 5 Other (Specify) 20b. Placa of Disposition cemetery, cremetor, FOREST OAK	y or other place)	Date 20c.	. 20850 Location - City or Town, State ITHERSBURG, MD.
Important: If any injury or once.			FUNERAL HOM AYTONSVILLE,	
sician edical miner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition condition resulting in death)		erdiac or respiratory arrest,	Approximete Interval Between Onset end Death
ettending physician and for usa as the bunal-transit clan/Medical Examiner	Cause (Disease or Injury that initiated events resulting in death) Last Cause (Disease or Injury that initiated events resulting in death) Last	∍on: Heart Failu	re	Minutes Unknown
by the ettending i etached for usa as Physician/Me	Part II. Other significant conditions contributing to death but not resulting in the under	ving cause given in Part I.	23b. Did tobec	co use contribute to the cause of deeth?
be detached by Physic			1 Tes	
2 should pieted			24a. Was an au pertormed	24b. Were eutopsy findings evailable prior to completion of cause of death?
rector, page			1 □ Yes	2X No 1 □ Yes 2XNo
= 0	Hospital:	Other	of Death (Check only one) Ing Home 5 ☐ Residence	6 □Other (Specify)
iner in		28c. Injury at Work? 1 Yes 2 No	28d. Describe how in	njury occurred
To the Funeral Director: A completely filled in by the fi			place, end due to the cause	e(s) and manner es stated.
To the Complete	29b. Signature end title of certifier	29c. License number D005 3 38		Dete signed (Month, Dey, Yeer) gust 21, 1998
	30. Name and address of person who complete cause of death (Item 23a) (Type, Print Dr. Eugene Spagnoula, 9901 Medical Center 31. Dete filed (Month, Day, Yeer) 32, Registrar's Signature	•	le, Md. 2085	0
State Registrar		souls!		

DHMH 16 Rev 6/95

AUG 2 4 1998



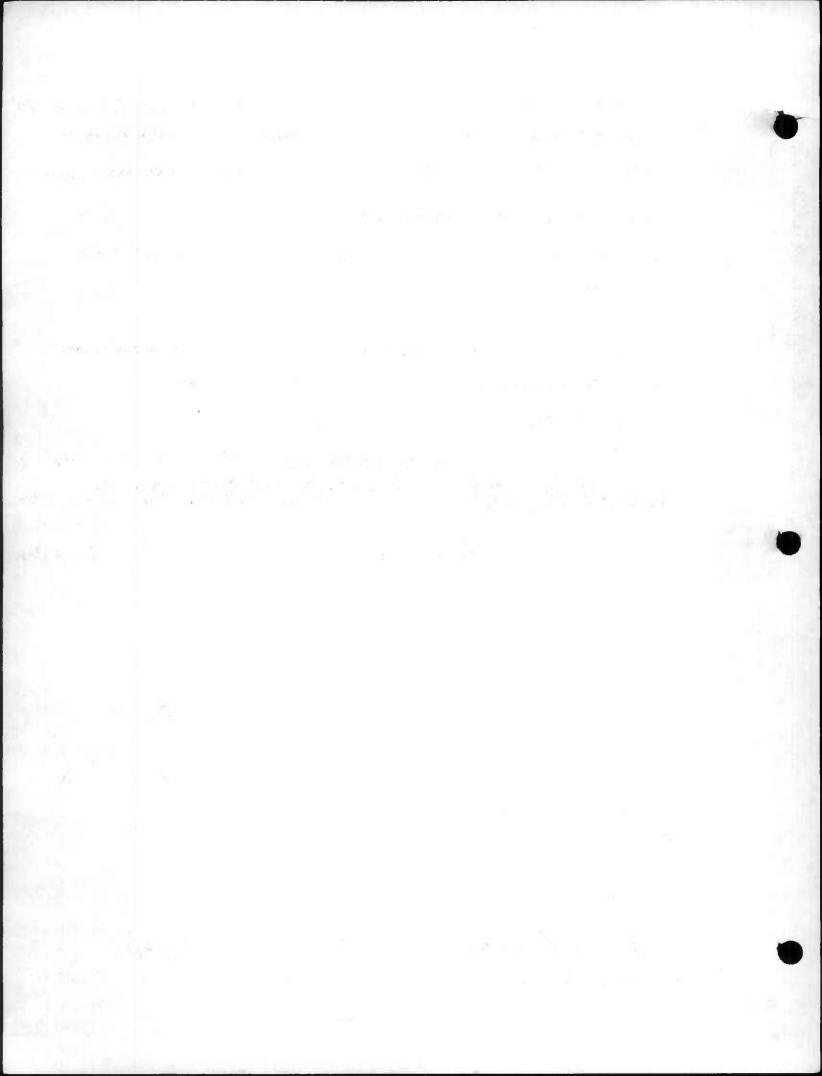
State of Maryland / Department of Health and Mental Hygiene

cian	James M. Wil	son, Jr.				2. Date of Deal Month	Day	3. Time of			
lical iner	4a. Facility Neme (If not institution, give				4b. City, Town, or L	ocation of Death	4c. County of	1998 5:2.	3 AM		
niei	Doctor's Commu				Lanham	33 - 1705-55		George's			
it r	5. Social Security Number 6. Sr 212–64–4826 3	Div D -	lest birthday) 45 Yrs.	Months Deys		8. Date of Birth (Month, Day) May 28	1953	9. Birthplace (State of Country) Washingtor			
	10a. State 10b. County	10c. Cit	y, Town or Loc	cation				10d. Inside Clt	ty Limits		
Director	Maryland Prince G	eorge's Co	11ege 1	Park				XX Yes	2 🗍 No		
	10e. Street end Number 4834 Indian Lane			10f. Zip Code 2074	0	1	Og. Citizen of W United	het Country? States			
by Funeral	11. Marital Status 1 Never Married XX Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2XXIo If Yes, Give Year or Datas:		/as Dacedent of Yes, specify Cub	Hispanic Origin? (Spean, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		- American Indian, K, White, etc. White			
	15. Decedent's Ed (Specify only highest grad	ucation	16e. Deced	ent's Usual Occu	pation	ina	16b. Kind of Bus	siness/Industry			
Completed	Elementary/Secondary (0-12)	Collega (1-4or 5+)		ONOT usa retire	during most of work d)	9	America	n Potomac			
Be Co	17. Fathar's Name (First, Middle, Last)			_	18. Mother's Nam		-	e)			
10	James M. Wil	son, Sr.	105 11-11-	A 11 (O	JoAnn		hr	2			
To Be Comp	Karie J. Wilson (ame as #	t and Number or Rui 10	ei Houte Number	, City or Town, S	State, Zip Code)			
	20a. Method of Disposition 1 Burial XXCremation 3			sition (Neme of etory or other ple	oce)			City or Town, State			
	4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen	Me	-	itan Cre	IIIA COL Y			ndria, Virg	ginia		
	Manual V. B	toward.	Do 44	onald V. 400 Powd	ass of Facility Borgward er Mill R	t Funera d. Belts	1 Home, sville,	P.A. Maryland 2	20705		
	23a. Pert1. Enter the disease, or comp shock, or haart failura. List only of	lications that caused the deat one cause on each line.	h. Do not ente	r the mode of dy	ng, such es cardiac	or respiretory erro	est,	Approximate Interval Bety Onset and D	veen		
П	Immediata Cause (Final	Cir	chosi	`c				6 me			
	disease or condition resulting in death)	0,	or es e consequ					6771	,		
Examiner		b. ————————————————————————————————————		P							
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edical	that initiated avants rasulting In death) Last	C. Due to (o	r es e consequ	ence of):							
		d							71		
Physician/N	Part II. Other eignificant conditions co	ntributing to death but not res	ulting in tha un	darlying ceuse gi	ven in Part I.	23b. Did to	bacco uaa con	tribute to the cause o	f death?		
						1 🗆 Y	2 2 No	3 ☐ Probably 4 ☐ I	Unknown		
pleted by						24a. Was a perform		24b. Were eutopsy fi eveilable prior to completion of co of deeth?	0		
Compl						1 □ Y€	s 200No	1 □ Yes 2	No		
Be	25. Was cesa raferred to medical examiner?	Hospital:		Ot	26. Place of Deat						
ation: To	1 Yes 2 No 27. Manner of Daath 1 Natural 5 Pending 2 Accident investigation	28a. Data of Injury (Month, Dey Year)	ER/Outpatient 28b. Time of Injury	28c. Inju	DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 Yes 2 No						
Certification:	3 Suicide 6 Could not be 4 Homicide detarmined	28e. Place of Injury - At he building, atc. (Spacifi	ome, farm, stra	at, factory, office		28f. Location (St City or Town		er or Rurel Route Numi	ber,		
edlcai	29a. Cartifiar (Check only one) Certifying Phy	alcian: To the best of my kno iner: On the basis of axamina and mannar stated.	wledga, daath tion and/or Inve	occurred at the ti estigation, in my	me, date and place, opinion, daath occur	and due to tha cared at tha time, do	use(s) and mar ate and place, a	nnar as stated. nd dua to tha cause(s)			
Σ	29b. Signature and title of certifier	R a		29c. Licen				(Month, Day, Year)			
	30. Name and addrass of person who come ichael Ber	Heard		D:	26287		8/22/	198			
	30. Name and addrass of person who c	omplated ceusa of daath (Itam	Balta	more A	r 107	Co le	2 Park	MD 207	140		
	THE THE POPULATION	100	. 20.01.1					_			

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760,

Ju James Montgomery Wilson Jr. Baltimore, Maryland 21215-0020



GERTRUDE WEIL Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink.	Assure All Copies Are Legible
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State of Maryland / Department of Health and Mental Hygiene

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iner	4a. Facility Nama (If not institu DOCTORS ' HOSI								LANH	AM	ocation of	ath	PRINCI		RGE'S	
	5. Social Sacurity Number 067-09-1038 Usual Rasidanca of Dacedant	6. Sax	M 2017F	7. Aga (In) 84		Yrs.	If Undar Months	1 Yaar Days	If Unda Hours	Min.	8. Data of (Month, July	Day,	Year) 1914	9. Birthp Cour New	placa (Stata o ntry) York	Foraig
tor	10a. Stata 10b. Cour Maryland Princ		orge':		. city, Tow Green									1	10d. insida Cl	
I Direc	10e. Straat and Number 29-B Ridge Roa	ad					10f. Zip	Coda 207	770			10	g. Citizan of U	What Cour	ntry?	
by Funeral Director	11. Marital Status 1 Navar Marriad 2 M 3 Widowad 4 Divorce	larriad	Armed F	2 No	in U,S.		Vas Daced Yas, spec		lispanic Oi an, Maxica Spacify		ecify Yas or Rican, atc.)	No-		ck, Whita,	can Indian, atc.	
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To	Barnett Primac		oe, Print)		196	o. Mailing	g Addrass	(Straat			olier ral Route Nu		Mack City or Town,	Stata, Zip	o Coda)	Н
	Teddy Primack 20a. Mathod of Disposition 1 □ Burlal 2 🛱 Cramatio			State	b. Placa o camate	of Dispos	sition (Nam	a of thar plac	ca)		belt,	20	Oc. Location -			
	4 Donation 5 Other 21. Signature of Furnal Service	(Spacify)		00173	(etro		tan (27-98 warv	P	Alexand	dria,	VA	-
,	23a Par Linu I tW6 disaasa pock, or heert failura. L tmmadiata Cause (Final disaasa or condition resulting to death)	or complicing the street of th	cations that e causa on a	Piras	death. Do	not anta	ne tha mode						st, MD	1	Approximate Interval Betto Onset and I	reen
vMedical Examiner	tmmadiata Cause (Final disaasa or condition	or compliate only on a b	cations that e causa on	Dua to	tin	consaqui	uance of):								Interval Bety	reen
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